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 Pharmacy Department Fax:  
**413-233-2777**

# Medication Request Form

**Instructions:**  
 This form is to be used by participating physicians and pharmacy providers to obtain coverage for the Exceptions listed below, along with Medicare Part B Exceptions. Complete this form and fax to Health New England Pharmacy Services Department at **413-233-2777**. For Medicare Part B Requests please refer to the section below. If you have any questions regarding this process, contact Health New England Member Services Department at (800) 310-2835. For any Medicare Part D requests please visit [www.hne.com/medicare](http://www.hne.com/medicare) for further information.  
**To Prevent any Delays in Processing Please complete all Patient Information and Drug Information**

PATIENT INFORMATION (ALL REQUIRED):		PRESCRIBER'S INFORMATION	
PATIENT NAME:		PRESCRIBER'S PRINTED NAME:	SPECIALTY:
PATIENT HNE ID#:		NPI #:	HNE PROVIDER#:
PATIENT DATE OF BIRTH:		OFFICE PHONE #: ( ) -	OFFICE FAX #: ( ) -
ALLERGIES:		OFFICE CONTACT NAME:	
DIAGNOSIS:		PHYSICIAN SIGNATURE:	DATE:
CO-MORBID CONDITIONS WHICH MAY BE RELEVANT:			

DRUG INFORMATION:		
REQUESTED DRUG NAME:	PAST FAILURES/DATES TRIED:	TYPE OF EXCEPTION (CHECK ALL THAT APPLY): <input type="checkbox"/> *Please allow 3-15 days for processing
DOSE/STRENGTH/FORM (please be specific):	REASON FOR DISCONTINUATION (attach additional information when applicable):	<input type="checkbox"/> QUANTITY LIMITATION Reasons for exceeding limit:
FREQUENCY PER DAY/QUANTITY PER MONTH:		<input type="checkbox"/> STEP THERAPY Patient has filled a prescription and tried a step 1 (generic) drug in the previous 180 days. THIS EXCLUDES THE USE OF SAMPLES
DURATION OF REQUESTED TREATMENT:		<input type="checkbox"/> MULTISOURCE BRAND Documented allergic reaction to generic formulation (please attach form)
SIGNIFICANT LAB VALUES:		<input type="checkbox"/> NEW-TO-MARKET *For Commercial HNE Members an approval will result in a copay of \$50 or 50% of the price of the drug whichever is greater.

**THIS SECTION APPLIES ONLY TO HNE MEDICARE ADVANTAGE MEMBERS**

Please fax Medicare Part B Prior Authorization requests to: HNE Health Services Department 413-233-2700

REQUESTED DRUG NAME (INCLUDE STRENGTH):	DIRECTIONS:	OTHER PERTINENT INFORMATION (attach additional information when applicable):
HOW WILL PROVIDER BE ADMINISTRATING (BUY AND BILL OR PHARMACY PRESCRIPTION):		
DIAGNOSIS OR CONCURRENT DISEASE STATES:		
PLEASE LIST ANY CONTRAINDICATIONS TO FORMULARY, ALTERNATIVE OR GENERIC MEDICATIONS:		