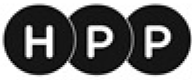

Health Partners Plans

PHARMACY BENEFIT LIMIT EXCEPTION REQUEST FORM

Medicaid Only

Phone: 215-991-4300 **Fax back to: 866-240-3712**

For additional information on the Pharmacy Benefit Limits, please refer to Medical Assistance Bulletin titled Medical Assistance Pharmacy Benefits Package Change. To view the Medical Assisntance Bulletin and Handbook go to: http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Member Phone:	Specialty/facility name (if applicable):	

Patient belongs to: ☐ *Health Partners*

PLEASE SEND THE COMPLETED FORM WITH CLINICAL INFORMATION (SUCH AS CHART NOTES, LAB RESULTS, ETC.) THAT SUPPORTS THE INFORMATION ON THIS FORM.

Medication(s) Requiring Exception to the benefit limit:

Drug/Strength:________________________________ Directions: ___________________________ Quantity/Month: ______ Refills: ___

Drug/Strength:________________________________ Directions: ___________________________ Quantity/Month: ______ Refills: ___

Drug/Strength:________________________________ Directions: ___________________________ Quantity/Month: ______ Refills: ___

Drug/Strength:________________________________ Directions: ___________________________ Quantity/Month: ______ Refills: ___

Drug/Strength:________________________________ Directions: ___________________________ Quantity/Month: ______ Refills: ___

Q1. Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member. ☐ Yes ☐ No
Q2. If yes, please explain and provide supporting dcoumentation from the medical record:
Q3. Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the member. ☐ Yes ☐ No
Q4. If yes, please explain and provide supporting documentation from the medical record:
Q5. Patient would require more expensive services if the exception is not granted. ☐ Yes ☐ No
Q6. If yes, please explain and provide supporting documentation from the medical record:
Q7. It would be against federal law for Health Partners to deny the exception. ☐ Yes ☐ No
Q8. If yes, please explain and provide supporting documentation from the medical record:

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Patient Name:	**Prescriber Name:**

Q9. Please list all of the receipient's current medications:

Q10. Current Meds (con't):

Q11. Is this a new prescription for a drug that also requires prior authorization? If yes, please submit the documentation of medical necessity of the drug along with the clinical information to support the request for an exception to the benefit limit.

☐ Yes ☐ No

Q12. Additional Information/Comments:

Prescriber Signature

Date

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