PREVEA360 Medicare Advantage
from Dean Health Plan

Medicare Step B Therapy Exception to Coverage Request

Allow 72 hours for Processing Complete Legibly to Expedite Processing

COMPLETE REQUIRED CRITERIA AND FORWARD TO:	Prevea 360 Pharmacy Services 1277 Deming Way Madison, WI 53717 Fax: 608-252-0840		
Date:		**Prescriber Name:**	
Patient Name:		**Prescriber NPI:**	
Unique ID:		**Prescriber Phone:**	
Date of Birth:		**Prescriber Fax:**	

REQUEST TYPE:	☐ **Non-Preferred Drugs[1]**	☐ **Part D Drugs First[2]**

[1] **Non-Preferred Drugs:** All formulary preferred must have been tried within the last 365 days and treatment failed or is contraindicated. Complete the formulary alternatives table and indicate clinical rationale.

[2] **Part D Drugs First:** Prior use of **oral** Part D medications before Part B medication is started. Indicate usage of all formulary preferred and clinical rationale and dates of treatment failure or contraindication.

REQUESTED DRUG INFORMATION		**INDICATION / REASON FOR USE / CLINICAL RATIONALE**
DRUG*		
STRENGTH		
FREQUENCY		
QUANTITY		

Please list ALL Preferred Agents that MEMBER has tried within the LAST 365 DAYS:

Preferred Agents	Max Dose Used	Dosing Frequency	Use Start-End Dates	Describe Specific and Significant Side Effects and/or Ineffectiveness

** If complex medical management exists, supply supporting documentation with this request.

If Approved, Coverage is Granted for One Year

Prescriber Signature:_____ **Date:**_____

Access Formularies via our Provider Portal www.prevea360.com > For Providers> Provider Login