

**Medicare Step B Therapy  
 Exception to Coverage  
 Request**

**Allow 72 hours for Processing Complete  
 Legibly to Expedite Processing**

**COMPLETE REQUIRED CRITERIA AND FORWARD TO:**

Navitus Health Solutions  
 5 Innovations Court, Suite B  
 Appleton, WI 54914  
 Fax: 855-668-8551 (toll free) 920-735-5350 (Local)

<b>Date:</b>		<b>Prescriber Name:</b>	
<b>Patient Name:</b>		<b>Prescriber NPI:</b>	
<b>Unique ID:</b>		<b>Prescriber Phone:</b>	
<b>Date of Birth:</b>		<b>Prescriber Fax:</b>	

**REQUEST TYPE:**  **Non-Preferred Drugs<sup>1</sup>**  **Part D Drugs First<sup>2</sup>**

<sup>1</sup> **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.

<sup>2</sup> **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
<b>DRUG*</b>		
<b>STRENGTH</b>		
<b>FREQUENCY</b>		
<b>QUANTITY</b>		

**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:** \_\_\_\_\_