Print Form

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

INSTRUCTIONS

Important: Please read all instructions and information before completing the form.

Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

Note: This version of the form (C-1.0) is current as of July 2010, and supersedes the following previous versions of Minnesota Department of Health forms for PA requests and formulary exceptions:

- Example Minnesota Prescription Drug Prior Authorization (PA) Request Form, version 1.0 2/15/10
- Minnesota Uniform Formulary Exception Form, version 1.0 September, 2009

This form will not change frequently. The form version number and most recent revision date are displayed in the lower right corner.

Overview:

The following form is made available by the Minnesota Department of Health (MDH) pursuant to statute, to facilitate exchanges of information between prescribers and patients' insurance carriers, HMOs, Pharmacy Benefits Managers (PBMs), or other payers* of prescription drug claims.

Intended use and requirements:

The form is intended primarily for use by prescribers, or those designated and authorized to act on behalf of prescribers, to:

1. **Request an exception to a prescription drug formulary.**
   - Requests for formulary exceptions are requests to make nonformulary prescription drugs available to a patient as a formulary drug.
     - Laws 2010, chapter 336, section 4 requires that all health care providers must submit requests for formulary exceptions using the uniform form, and that all payers must accept this form from health care providers. No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. Note: A previous restriction in law that facsimile was not considered "secure electronic transmission" was removed in 2010.
2. **Request a prior authorization (PA) for a prescription drug.**
   - Prescription drug prior authorization requests are requests for pre-approval from a payer for specified medications or quantities of medications.
     - Laws 2010, chapter 336, section 5 requires that by January 1, 2015, drug PA requests must be accessible and submitted by health care providers, and accepted by payers, electronically through secure electronic transmissions.

Additional Instructions:

- Prescribers, or their designees, use parts A-F as applicable. Payers making the form available on their websites may pre-populate section A. Payers use section G when responding to requests.
- Payers may request additional information or clarification needed to process formulary exceptions and PA requests.
- Payers may supply additional instructions or other relevant or legally required information with their response.
- Complete section F when submitting prescription drug PA requests to the Minnesota Department of Human Services.

* Note: The term "payers" is used to avoid possible confusion. The electronic submission and acceptance requirements of Minnesota Statutes § 62J.497, subd. 4 and 5, apply to "group purchasers". The term "group purchaser" is defined in Minnesota Statutes § 62J.03, subd. 6 and can be considered more commonly as "payer".

Print Form

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

See additional instructions and overview, Instructions page.

Please check the appropriate box below (check only one box). This form is being used for:

☒ **Formulary Exception** ☐ **Prior Authorization (PA) Request** ☐ **Unsure/Unknown**

A | Destination This form is being submitted to: (Payers making this form available on their websites may pre-populate section A.)

Payer Name: Office of Student Health Benefits; University of Minnesota

Payer Contact Name: Mimi Mekonnen, Health Benefits Analyst
(IF AVAILABLE)

Payer Address: 410 Church Street SE City, State, ZIP: Minneapolis, MN 55455

Payer Phone: 612-625-2031 Secure Fax: 612-435-4230 Other: _____

B | Patient Information

When filling Patient Health Plan ID number below, please note: If the patient has prescription benefits that are separate or "carved out" from the health plan benefits, provide the patient's prescription benefit card ID number (the "cardholder ID"). If the patient's prescription benefits are integrated with the health plan coverage (if there is no separate prescription benefit ID number), provide the patient's health plan ID number.

Patient Name: _____ DOB: _____
(LAST, FIRST, MI) (MM / DD / YYYY)

Patient Address: _____ City, State, ZIP: _____

Gender. Please Check Box: ☐ Male ☐ Female ☐ Unknown

Health Plan or Prescription Plan: _____ Patient Health Plan ID No.: _____
(OR PRESCRIPTION PLAN ID IF DIFFERENT THAN HEALTH PLAN ID)

C | Prescriber Information

Prescriber Name: _____ NPI: _____ Specialty: _____
(LAST, FIRST, MI)

Prescriber Business Address: _____ City, State, Zip: _____

Prescriber Phone: _____ Prescriber Secure Fax: _____

Prescriber Point of Contact (POC) Name: _____ POC Phone: _____ POC Secure Fax: _____
(IF DIFFERENT THAN PRESCRIBER) (IF DIFFERENT THAN PRESCRIBER)

Clinic/Location/Facility Name: _____ Clinic/Location/Facility Contact Name: _____

Clinic/Location/Facility Phone: _____ Secure Clinic/Location/Facility Fax: _____

Clinic/Location/Facility Address: _____ City, State, ZIP: _____

D | Prescription Drug Information (Medication information)

When completing this section and the following section (E), medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.

Drug Being Requested: _____ Strength: _____
(REQUESTED DRUG NAME) (E.G., 30 MG, 15 MG/ML, ETC)

Dosing Schedule: _____ Date Therapy Initiated: _____

Duration of Therapy Expected: _____ Authorization Start Date: _____

Clinical Drug Trial Request? ☐ Yes ☐ No
(NOTE: THE MINNESOTA DEPT. OF HUMAN SERVICES DOES NOT COVER CLINICAL DRUG TRIALS.)

Is Dispense as Written (DAW) Specified? ☐ Yes ☐ No

Rationale for DAW? _____

Is patient currently being treated with the drug requested? ☐ Yes ☐ No Date Started: _____

Print Form

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

E | Patient Clinical Information

Diagnosis Related to Medication Request: _____
(INCLUDE ICD-9 CODES WHEN AVAILABLE)

Drug Allergies: _____ Height: _____ Weight: _____
(IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST)

PREVIOUS THERAPIES TRIED / FAILED (list name, date prescribed, etc., in boxes below. Note: Medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.):

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Describe Adverse Reaction or Efficacy Failure

RATIONALE FOR REQUEST (and also include any additional pertinent clinical information/comments regarding rationale): _____

F | Pharmacy Information – For PA Requests to the Minnesota Department of Human Services (DHS)

Pharmacy Name: _____ National Provider Identifier: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

NDC Number for Prescription Drug Being Requested: _____ Pharmacy Fax: _____

G | Request Determination (may be completed by payers and sent to providers)

Date Request Received by Payer: _____ Date of Decision: _____

Payer Responder/Contact Name: _____ Payer Respondent/Contact Phone and/or Email: _____

Request Approved/Denied: ☐ **Approved** ☐ **Denied** Pharmacy Authorization/Reference No.: _____
(IF APPLICABLE TO PAYER)

Comments Regarding Decision: _____
(INCLUDE EFFECTIVE AND END DATES OF DECISION IF APPLICABLE)

Additional Information or Instructions
Note: Group purchasers may supply additional instructions or other relevant or legally required information with their response. Examples of additional information might include: Appeals rights and processes; other notifications; other information required for legal or clarification purposes. _____

CONFIDENTIALITY NOTICE: The information in this form is confidential and intended for the use of the recipient. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance of the contents of this communication is strictly prohibited. If you have received this form in error please immediately notify the sender to arrange for its return. Thank you for your assistance.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health July, 2010

V. C-1.0 JULY2010