

**Prescription Drug Reference Pricing Program
Lower Copay / Cost Share Reduction Prior Authorization Form**

Fax To: 866-511-2202

Mail To: Prior Authorization Department
P.O. Box 3214, Lisle, Illinois 60532-8214
Phone: 800-626-0072

Patient Information:

Name: _____ Date of Birth: _____ Member ID: _____

Pharmacy Information:

Name: _____ Phone: _____ Fax: _____

Medication Information:

Name and Strength of Drug: _____ Quantity & Dosing: _____

Diagnosis: _____ Duration of Therapy: _____

*****Prescriber MUST submit a statement of clinical justification indicating any ONE of the following below*****

Please select all that apply and provide statement of clinical justification

☐ **Low Cost Alternative Drug is contraindicated due to any of the following:**

- Adverse outcome, Drug interaction, Toxicity, or Allergy

☐ **Low Cost Alternative Drug has been previously tried with therapeutic failure**

☐ **Patient is stable on current drug(s) AND has high risk of significant adverse clinical outcome with medication change**

- Provide information indicating this is a continuation of therapy request (e.g., length of therapy, start date, etc.) **AND**
- Provide clinical justification indicating high risk of destabilization, significant adverse clinical outcomes are likely if discontinued

☐ **Low Cost Alternative Drug would be less effective in this patient**

- Drug itself is less effective in this patient, or
- Patient would be less compliant on the Low-Cost Alternative Drug

☐ **Prescriber documents "DAW-1" AND provides supporting clinical information**

- Must state, Dispense as Written 1= Substitution Not Allowed by Prescriber
 - Only Daw-1 is considered
 - All other DAW Codes are not accepted (e.g., DAW 0, 2-9)

AND

- Provide clinical justification that meets any ONE of the clinical criteria outlined above

☐ ****REQUIRED** Statement of clinical justification: (Information to be considered and used in determination of this exception.)**

Prescriber Information:

Name: _____ Specialty: _____

DEA/NPI: _____ Phone: _____ : _____

I attest that the information given on this form is accurate as of this date.

Prescriber or Authorized Signature

_____ Date: _____