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-2.0) is current as of October 2015, and supersedes previous versions of Minnesota Department of Health forms for PA requests and formulary exceptions.

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.
     - Minnesota Statutes, section 62J.497, Subd. 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.
     - Minnesota Statutes, section 62J.497, subd. 5 requires that by January 1, 2016, drug PA requests must be accessible and submitted by health care providers, and accepted by payers, electronically using the NCPDP SCRIPT Standard version 2013101.

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".
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: 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: Hennepin Health
Payer Contact Name (if available):
Payer Address: 400 South Fourth Street, Suite 201
City, State, Zip: Minneapolis, MN 55415
Payer Phone: (612) 596-1036
Secure Fax: (612) 321-3712
Other: E-mail: HH.Pharmacy.PA@hennepin

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 (LAST, FIRST, MI):________________________
DOB:________________________  Gender:________________________
City, State, Zip:

Patient Address:
Health Plan or Prescription Plan:
Patient Health Plan ID Number:

C | Prescriber Information

Prescriber Name (LAST, FIRST, MI):________________________
NPI:________________________  Specialty:________________________
City, State, Zip:

Prescriber Business Address:
Health Plan or Prescription Plan:
Patient Health Plan ID Number:
Prescriber Secure Fax:

Prescriber Phone:
Prescriber Point of Contact (POC) Name:
POC Phone:________________________  POC Secure Fax:________________________

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:

“X” DEA number (buprenorphine prescriber status number, always preceded by “x;” issued per the Drug Addiction Treatment Act of 2000 (Data 2000)):

D | Prescription Drug Information (Medication information)

When completing this section and the following section (E), medication “strength” is usually expressed in milligrams, e.g., 30mg, 15mg/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. If request is for a Minnesota Department of Human Services recipient, please also fill out Section F.

Drug Being Requested:________________________
Strength:________________________  (E.g., 30 mg, 15 mg/ml, etc.)

Dosing Schedule:________________________
Date Therapy Initiated:________________________
Duration of Therapy Expected:________________________
Authorization Start Date:________________________
Clinical Drug Trial Request? _______________________
Is Dispense as Written (DAW) Specified? _______________________

(SEE NOTE THE MINNESOTA DEPT. OF HUMAN SERVICES DOES NOT COVER CLINICAL DRUG TRIALS)

Rationale for DAW:

Is patient currently being treated with the drug requested? _______________________
Date Started: _______________________
# E | Patient Clinical Information

Diagnosis Related to Medication Request: 

Drug Allergies: ____________________________________________________________________________

Height: ___________  Weight: ___________

(RELEVANT TO THE REQUEST)  (RELEVANT TO THE REQUEST)  (RELEVANT TO THE 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.):

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>Dosing Schedule</th>
<th>Date Prescribed</th>
<th>Date Stopped</th>
<th>Describe Adverse Reaction or Efficacy Failure</th>
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</tr>
</tbody>
</table>

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

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# F | Pharmacy Information

Pharmacy Name: ____________________________________________________________________________

NPI: ___________  Pharmacy Phone: ___________

Pharmacy Address: _________________________________________________________________________

City, State, Zip: _______________________________________________________________________

NDC Number for Prescription Drug Being Requested: ___________

Pharmacy Fax: __________________________________________________________________________

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# 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 Responder/Contact Phone: _______________________________________________________________________

Payer Responder/Contact Email: _______________________________________________________________________

Request Approved/Denied: ___________________________________________________________________________

Pharmacy Authorization/Reference Number: _______________________________________________________________________

(RELEVANT TO PAYER)  (RELEVANT TO PAYER)

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

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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.

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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.

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This form was approved by the Commissioner of the Minnesota Department of Health