Medication Coverage Request Form

840 Carolina Street • Sauk City, WI 53583-1374
(800) 362-3310 • Fax (888) 450-4711
Self-Funded: (800) 805-0693
QuartzBenefits.com

Completed form can be submitted via mail or fax to (888) 450-4711

- For most expedient review: Forms should be completed by health care provider and submitted via fax
- Requests can also be initiated via telephone: (888) 450-4884
- To check the status of a PA request, contact Quartz Customer Service: (800) 362-3310. For Self-Funded participants, please call Quartz Customer Service Care Advocates: (800) 805-0693.
- Additional information, including Prior Authorization criteria and FAQs, can be found at QuartzBenefits.com/providers

If request is for a nonformulary drug, information must be submitted that supports that all therapeutic alternatives will be or have been ineffective, would not be as effective as the requested drug or would have adverse effects. To request a review be processed as urgent / expedited you must write "URGENT" at the top of this form. By doing this, you certify that applying the standard time frame may seriously jeopardize the patient's life, health, or ability to regain maximum function or that the patient is undergoing a current course of treatment using a nonformulary drug. Documentation must be provided below FROM THE PRESCRIBER indicating why the request is urgent / expedited. **Without documentation to support urgency, request may be treated as a standard request.**

Support for need for urgency – _____

Note: Quartz has a New Member Override which may be used if the provider is unable to clinically support the need for an urgent / expedited review as outlined above and patient is currently taking a restricted medication. This will grant a fill immediately, and allow time to complete a standard coverage request without interrupting the patient's therapy. Call MedImpact Customer Service at (800) 788-2949 to obtain this authorization.

PATIENT INFORMATION			
Name	Birth Date	ID #:	Date:

PRESCRIBER AND PHARMACY INFORMATION		
Prescriber Name:	Prescriber Specialty:	
Prescriber Office Contact:	Prescriber Phone:	Prescriber Fax:

DIAGNOSIS AND MEDICATION INFORMATION	
Diagnosis	Check One: ☐ New Therapy ☐ Current Therapy
Medication Name/Dose/Frequency:	Duration of Therapy:
Provide the reason / clinical rationale for the request. Include relevant past medical history, allergies, labs, supporting documents / clinic notes, medication trials (including names, doses, dates, detailed outcomes, such as lack of efficacy or adverse reaction), contraindications to preferred / first line therapies, and documentation why preferred / first line therapies would be expected to not work or cause harm.	

FOR CLINIC / PHYSICIAN ADMINISTERED MEDICATIONS ONLY (MEDICAL BENEFIT)		
Administering Provider Name:	Provider Phone:	Provider Fax:
Providing Facility:	Facility Phone:	Facility Fax:
Procedure Code / Description:		

Prescribers will be notified by fax and members will be notified by mail when a decision has been determined