Appendix A: Standard Exception Form for Contraceptives

REQUEST FOR AN ALTERNATIVE CONTRACEPTIVE FOR PATIENTS COVERED UNDER A COLORADO HEALTH BENEFIT PLAN (other than self-funded ERISA coverage, Medicaid, Medicare, and TRICARE)

Carriers must cover a non-formulary contraceptive without cost-sharing upon the recommendation of the patient's health care provider.

If the carrier, or pharmacy benefit management firm acting on behalf of a carrier, requires a written request for a non-formulary contraceptive, the provider must complete this form and send it to the patient's health benefit plan to obtain coverage of a contraceptive that is not on the plan's prescription drug formulary, but is determined to be medically necessary for the patient by the provider.

Patient Information		
Name		**Date of Birth**
Address		
City	**State**	**Zip Code**
Health Insurer Name	**Patient's Member ID #**	

Attending Health Care Provider Information		
Name		
Address		
City	**State**	**Zip Code**
Office Phone	**Fax**	
Tax ID # / NPI # (if available)	**Facility Name (if applicable)**	
Office Point of Contact	**Preferred Contact Method**	

Alternative Contraceptive Request (to be completed by the attending health care provider)

The covered therapeutic and pharmaceutical equivalent versions of a contraceptive are: (check one)

- □ Not available; OR
- □ Deemed medically inappropriate

Requested Alternative Contraceptive: (complete applicable items)
I, the patient's attending health care provider, in my reasonable professional judgment, have determined that the use of the non-covered therapeutic or pharmaceutical equivalent of a contraceptive listed below is warranted.

Contraceptive Name	**Strength**	**Quantity per Month**
J-code	**Units Requested**[1]	**Proposed Date of Service**
□ **Check if a generic equivalent may be substituted for the requested contraceptive drug, device, or product.**		

Exception Request

NOTE: Per Colorado law, a carrier that receives this exception request for a non-formulary contraceptive shall consider that request as an expedited exception request and must respond within 24 hours following receipt of this request. Carriers are prohibited from requiring a covered person, a person's authorized representative, or an individual's provider to appeal an adverse benefit determination for a contraceptive using the carrier's internal claims and appeals process.

Signature

I certify that the information provided in this form is accurate to the best of my knowledge.

Health Care Provider's Signature	**Date**

Send the completed form to:

[1] Pursuant to section § 10-16-104.2, Colorado Revised Statute, carriers must reimburse a participating provider for prescription contraceptives intended to last for a 12-month period.

Fax Number:
303-602-2081

Email:
ManagedCarePAR@dhha.org