ARGUS
Our Interest is You.

Specialty Drug Coverage Request Form

Health Insurance

Argus Health utilises the CVS Advanced Control Specialty Formulary to determine the list of approved specialty drugs, which can be found here.

Please click here for Argus Health Specialty Drug Programme policy definitions and FAQs.

The prescribing physician (General Practitioner or Specialist) is required to complete this coverage request form. Please use a separate form for each drug and submit the completed form and corresponding consult note for review and approval to **overseascare@argus.bm**

Patient Information	Prescribing Provider Information
Patient Name	Prescriber Name
Certificate Number	Prescriber Phone
Date of Birth	Prescriber Fax
Patient Phone	Prescriber Address
Patient Email	Provider Office Email
Prescriber Tax I.D. (overseas provider)	Provider NPI (overseas provider)

Medication/Medical and Dispensing Information

Medication Name				
☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request (see section below)				
☐ Paid under Insurance	Prescription Date			
☐ Other	Explain			
Dose/Strength	Frequency	Length of Therapy/ # of Refills	Quantity	Cost

Administration

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other

Administration Location

☐ Patient's home / Home Care Agency ☐ Long Term Care ☐ Physician's Office
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care ☐ Other (explain)

Required Clinical Information – Please provide all relevant clinical information and reference attachments

ARGUS
Our Interest is You.

Specialty Drug Coverage Request Form

Health Insurance

Step Therapy Exception Request

Instructions: Please complete all applicable sections. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has patient tried any other mediations for this condition?

☐ Yes (complete below) ☐ No

Medication/Therapy (Specify Drug name and dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses	ICD-10 Diagnosis Codes

Additional Information

Physician Name *(please print)* | Physician Signature | Date (MM/DD/YY)

For completion by the Insurer

☐ Approved

Authorisation Number	Case Number

☐ Denied

Reason for Denial

Coverage

Reviewer's Name *(please print)* | Reviewer's Signature | Date (MM/DD/YY)