Rare Diseases Medication

Coverage Request Form

Member name: Member ID: Date of Birth:

I understand that I am being prescribed treatment for a chronic condition. Because of the cost associated with this therapy, I confirm the following statements are true:

1. I am aware that the cost for this drug exceeds $20,000 each month.
2. I have received counseling and am prepared to take/receive this medication as instructed.
3. I am willing and able to attend all provider and lab appointments as determined by my provider and at a minimum of annually.
4. I am willing to participate in provider, pharmacy and/or health plan initiated outreach designed to ensure optimal outcomes.
5. I agree to inform my provider and pharmacy (when medication is dispensed from a pharmacy) if I stop taking my therapy as directed or am hospitalized for any reason.
6. I agree to inform my provider and pharmacy (when medication is dispensed from a pharmacy) of any changes to my contact information.

Member signature ____ Date ________________________

Provider signature ____ Date ________________________