Non-Formulary Treatment Clinical Review

Medication (completed by Pharmacy):

Cost per dose (completed by Pharmacy):

Number of doses:

Is inpatient status required to begin treatment?

Can any part of the treatment cycle be administered outpatient infusion &/or home care? If so, at what point?

The following are to be completed by: Requesting Provider

Any questions or barriers to obtaining information, please contact Jennifer Ellisonat 309-655-2286 or jennifer.c.ellison@osfhealthcare.org

1. Patient Name:
2. Patient DOB:
3. Is this patient already admitted to SFMC?
    a. If so, what room/bed number?
    b. Approximate date of discharge?
4. MRN (if applicable):
5. Does the patient have Decisional Capacity? Please explain.
6. Does the patient have any Advanced Care Planning (ACP) Documents?
    a. Power of Attorney for Health Care
    b. Living Will
    c. Other documents discussing DNR (do not resuscitate) orders, organ and tissue donation, dialysis, and blood transfusions.
7. If patient does not have ACP documents, has ACP be recommended to the patient?
    a. Is the conversation regarding ACP recommendation documented in EMR?
8. Diagnosis:
   Please answer 9-12 *or* fax/email most recent 'H&P' & most recent progress notes
9. Disease History:
10. Prognosis:
11. Co-morbidity:
12. Treatments/Medications that have been tried & failed:
13. **Name of Non-formulary Medication request**:
14. Treatment Course:
    a. Dose
    b. Frequency
    c. Anticipated length of therapy
    d. Will delay in treatment cause clinical significance? If so, why?
15. Any unique Risks/Side Effects to comment:
16. Appropriate care goals with treatment:
17. Will the medication be used in the way it is indicated? Please explain.

18. Success Rate of medication:
19. Alternatives (including no treatment &/or hospice):
20. Insurance Information (please provide front & back copy of card):
    a. Company:
    b. Identification #:
    c. Group #:
    d. Does insurance cover care at OSF-SFMC?
    e. If out of network, are there institutions that are in-network for this patient?
        i. If so, why is patient seeking care there?

If SFMC is the only feasible option for the patient but care is not covered at OSF-SFMC, provider may be contacted by SFMC to begin appeal process with insurance company.

21. Aware of any other Funding Available (i.e. Clinical trials, manufacturer benefits)?

Non-Formulary Treatment Financial Review

Completed by: SFMC Finance

1. Is SFMC in or out of network?
    a. If out of network, why is patient seeking services at an out of network hospital?
2. Cost per dose:
3. Please fill in tables

Inpatient	
DRG reimbursement	$
Add-on reimbursement for drug	$
Cost of drug	$

Outpatient	
Visit/APC reimbursement	$
Add-on reimbursement for drug	$
Cost of drug	$

4. Financial assistance from drug manufacturer?
5. Other Patient Assistance programs available excluding OSF Financial Assistance?
7. What is the projected financial burden to patient?
8. What is projected financial burden to organization?
9. Is an ABN or commercial waiver necessary or prudent?
    - If so, please complete appropriate document & send with completed Financial Review.

OSF HEALTHCARE SYSTEM

Patient:
MRN
DOB
DOS
HAR

Non-Covered Services Authorization

Insurance does not pay for some or all services provided to patients. Even some care that you or your health care provider have good reason to think you need. We expect that your insurance provider may not pay for the services below.

Service(s)	Reason your Insurance May Not Pay:	Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the services listed above. I may be asked to pay now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance **does not pay**, I am responsible for payment.
☐ **OPTION 2.** I want the services listed above, but do not bill my insurance. I may be asked to pay now as I am responsible for payment.
☐ **OPTION 3.** I don't want the services listed above. I understand with this choice, I am **not** responsible for payment.

Additional Information:

This notification states an opinion, not an official decision from your insurance company.

Signing below means that you have received and understand this notice. A copy is provided to you.

Signature of Patient or Representative:	**Date:**
Signature of OSF Witness:	**Date:**

Ethical and Moral Questions

Completed by: OSF Decision Team

Ethics is concerned with compassionate and competent care of the patient.

1. Are the OSF Decision team and the requesting physician interacting in a cooperative, mutual, and open manner for the best outcome of the patient?
2. Is the patient engaged in his or her care, aware of her or his medical condition, and involved in developing goals of care?
3. How does this treatment align with the Mission?
4. How does this treatment align with our Moral Tradition?
5. Have morally legitimate treatment alternatives, including palliative care or hospice, been discussed?
6. Have all payers been identified?

Final Decision: