PHYSICIAN CERTIFICATION OF EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____(print patient's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due PEBP's or its designee (Third Party Claims Administrator, Pharmacy Benefits Manager or Utilization Management Company) determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion, as the covered person's treating physician, I hereby certify to the following: Please check all that apply. NOTE: The requirements in #1 - #3 below must all apply for the covered person to qualify for an external review.

1) ☐ The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2) The covered person has a condition that qualifies under one or more of the following:
   - ☐ Standard health care services or treatments are not medically appropriate for the covered person, or;
   - ☐ There is no available standard health care service or treatment covered by PEBP that is more beneficial that the requested or recommended health care service or treatment.

3) ☐ The health care service or treatment I have recommended, and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

   ☐ The health care service or treatment recommended would be significantly less effective if not promptly initiated. Explain:

_____
_____
_____
_____
_____

It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard services or treatments. Explain:

_____
_____
_____
_____
_____

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional information if necessary).

Physician's Signature

Date