



Please complete ALL information below and fax your request to 1-888-671-5285

### ConZip® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for <b>GENERIC</b> <input type="checkbox"/> Request is for <b>BRAND</b> (unable to take the generic) <input type="checkbox"/> Check if request is for <b>continuation of therapy</b>	Strength:	Dosage Form:
Directions for Use:		

Clinical Information (required)
<b>Select the Type(s) of Coverage Determination Requested:</b> <input type="checkbox"/> <b>Non-Formulary</b> - Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year. <input type="checkbox"/> <b>Step Therapy</b> - Request is for an exception to try another drug before the requested drug being prescribed. <input type="checkbox"/> <b>Quantity Limit</b> - Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____
<b>Select the diagnosis below:</b> <input type="checkbox"/> Moderate to moderately severe chronic pain in patients requiring around-the-clock treatment for an extended period of time <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<b>Select the medication(s) the patient has a history of trial and failure, or intolerance to:</b> <input type="checkbox"/> Tramadol <input type="checkbox"/> Tramadol extended-release (ER) <input type="checkbox"/> Other drugs in the same class. Please specify: _____ <input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____
<b>Quantity limit requests:</b> Is there a high risk of significant adverse clinical outcome with medication change or dosage change? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please specify: _____
<b>Prescriber Attestation of Medical Necessity:</b> Does the provider attest that the current medication regimen, exceeding the current cumulative morphine equivalent dose (MED) threshold, is medically required? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Requests exceeding 7 Day Supply Limit for Opioid Naïve Patients:</b> Does the provider attest that in his/her clinical judgment, the requested day supply exceeding the current 7 day supply limit is medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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