



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

Ezallor™ Sprinkle 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 GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy	Directions for Use:	

Clinical Information (required)
<p>Select the Type(s) of Coverage Determination Requested:</p> <p><input type="checkbox"/> Non-Formulary- 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.</p> <p><input type="checkbox"/> Step Therapy- Request is for an exception to try another drug before the requested drug being prescribed.</p> <p><input type="checkbox"/> Quantity Limit- Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____</p>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Homozygous familial hypercholesterolemia</p> <p><input type="checkbox"/> Hypertriglyceridemia</p> <p><input type="checkbox"/> Primary dysbetalipoproteinemia (Type III hyperlipoproteinemia)</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Select the medication(s) the patient has a history of trial and failure, or intolerance to:</p> <p><input type="checkbox"/> Atorvastatin <input type="checkbox"/> Pravastatin</p> <p><input type="checkbox"/> Fluvastatin <input type="checkbox"/> Rosuvastatin</p> <p><input type="checkbox"/> Lovastatin <input type="checkbox"/> Simvastatin</p> <p><input type="checkbox"/> Other drugs in the same class. Please specify: _____</p> <p><input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____</p>
<p>Quantity limit requests:</p> <p>Is there a high risk of significant adverse clinical outcome with medication change or dosage change? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>If yes, please specify: _____</p>

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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