



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

### Coverage Determination Request Form (Page 1 of 2)

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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)			Strength:		Dosage Form:
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			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.					
<input type="checkbox"/> <b>Prior Authorization-</b> Request is for a drug that requires prior authorization under the plan ( <b>Note:</b> specific clinical questions may apply. Specific drug form may be available).					
<input type="checkbox"/> <b>Step Therapy-</b> Request is for an exception to the requirement to try another drug first.					
<input type="checkbox"/> <b>Quantity Limit-</b> Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____					
<input type="checkbox"/> <b>Tier Exception (Lower Copay) request-</b> Request for a lower copayment because there are other drugs that treat the same condition at the lower copayment. <b>Note:</b> Does not apply to the Specialty tier and is limited to the initial coverage phase.					
<b>What is the patient's diagnosis for the medication being requested?</b>					
_____					
ICD-10 Code(s): _____					
<b>What medication(s) has the patient tried and failed OR have contraindications to? (Specify all)</b>					
<b>Please list all medication(s) that treat the same condition that would not be as effective for the patient as the requested medication or would cause adverse effects:</b>					
<b>Use of High Risk Medications in the elderly (applies to patients ≥ 65 years only). <i>Examples include estrogens, sulfonylureas (e.g., glyburide), hypnotics (e.g., zolpidem), muscle relaxants (e.g., cyclobenzaprine).</i></b>					
Has a risk versus benefit assessment been completed for this request of a high risk medication (HRM) in an elderly patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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## Coverage Determination Request Form (Page 2 of 2)

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### Quantity limit requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change?  Yes  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?  Yes  No

If yes, please specify: \_\_\_\_\_

### FOR OPIOID THERAPY that exceeds 90 morphine milligram equivalent (MME)

Does the provider attest that opioid therapy above 90 MME per day is medically required?  Yes  No

### Opioid Requests exceeding 7 Day Supply Limit for Opioid Naïve Patients:

Does the provider attest that in his/her clinical judgment, the requested day supply exceeding the current 7 day supply limit is medically necessary?  Yes  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.