



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

Long Acting Sulfonylureas 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) <input type="checkbox"/> Check if request is for continuation of therapy	Strength:	Dosage Form:
Directions for Use:		

Clinical Information (required)
Select the Type(s) of Coverage Determination Requested: <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. <input type="checkbox"/> Prior Authorization - Request is for a drug that requires prior authorization under the plan. <input type="checkbox"/> Quantity Limit - Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____

Select the diagnosis below: <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information: Is there documentation that the risk versus benefit has been assessed 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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Select the medication(s) the patient has a history of trial and failure, or intolerance to: <input type="checkbox"/> Glimepiride <input type="checkbox"/> Glipizide <input type="checkbox"/> Glipizide extended-release (ER) <input type="checkbox"/> Other drugs in the same class. Please specify: _____ <input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____
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Quantity limit requests: 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 yes , please specify: _____
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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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