



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

Qbrexza™ 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"/> 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"/> Primary axillary hyperhidrosis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Clinical information: Has the hyperhidrosis persisted for at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a Hyperhidrosis Disease Severity Scale grade of 3 or 4? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Qbrexza prescribed by or in consultation with a dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
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: _____

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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