



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

Sprix[®] Coverage Determination Request Form

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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:			Strength:		Dosage Form:
<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			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"/> Short term (up to 5 days) management of moderate to moderately severe pain that requires analgesia at the opioid level					
<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					
Select the medication(s) the patient has a history of trial and failure, or intolerance to:					
<input type="checkbox"/> Celecoxib					
<input type="checkbox"/> Ibuprofen					
<input type="checkbox"/> Meloxicam					
<input type="checkbox"/> Naproxen					
<input type="checkbox"/> Other drugs in the same class. Please specify: _____					
<input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____					
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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