COVERAGE DETERMINATION REQUEST FORM

EOC ID:

CFI Non Formulary Exception

Phone: 800-361-4542 Fax back to: 866-414-3453

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Please note that Elixir will process the request as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:

Q4. What is the anticipated duration of therapy?

☐ Less than a month
☐ One to three months
☐ Three months to one year
☐ Lifetime

Q5. Have other formulary alternatives in this drug category/class been tried and failed?

☐ Yes ☐ No

Q6. Please list them below along with the date the medication was tried and failed:

Q7. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having?

☐ The patient has an allergy to the formulary alternative ☐ Other

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Patient Name:	**Prescriber Name:**

Q8. If OTHER, please describe below:

Prescriber Signature

Date