COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Elixir Step Therapy 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:

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

Q4. Please indicate below which medication you are requesting a Step Therapy exception for:

☐ Cholesterol Step Therapy
☐ ARB Step Therapy
☐ Ambien CR
☐ Boniva/Actonel
☐ Celebrex
☐ Daytrana
☐ Proton Pump Inhibitors
☐ Tricor
☐ Uloric
☐ Rhinocort
☐ Other

Q5. If the medication is OTHER, please specify below:

Q6. Please indicate below which step one medications have been tried and failed:

☐ Omeprazole
☐ Pantoprazole
☐ NSAIDS
☐ Alendronate

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☐ Prilosec OTC/Omeprazole OTC ☐ Lovastatin ☐ Simvastatin ☐ Pravastatin ☐ Zolpidem ☐ losartan/HCT, irbesartan, valsartan/HCT	☐ Fenofibrate, Triglide or Antara ☐ Oral ADD/ADHD medication(s) ☐ Fluticasone, Flunisolide, Nasonex, Veramyst or Nasacort AQ ☐ Allopurinol ☐ Venlafaxine IR or ER ☐ Other

Q7. If the medication is OTHER, please specify below:

Q8. Please indicate the dose and the dates of the trial for the specific step one drug or formulary alternative below:

Q9. If the patient has NOT previously tried and failed a step one medication or a formulary alternative, please indicate below why the patient needs to have an exception to the step therapy:

Prescriber Signature

Date