COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Medically-Accepted Indication Prior Authorization

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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

Q4. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc):

Q5. Please provide any supporting clinical statements such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request (if needed):

Q6. IF the request is for a compounded product, please check all that apply:

☐ The prescriber attests that the requested compounded product contains at least ONE prescription ingredient

☐ The prescriber attests that the requested compounded product is not a copy of a commercially

☐ The requested compounded product contains bulk powders

☐ The requested compounded product contain ONLY over-the-counter ingredients

☐ The request is for a renewal and the prescriber

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available FDA-approved product

☐ Dosage form being compounded is due to the patient being unable to use the commercially available product

☐ Patient is unable to use a commercial available product due to a hypersensitivity or allergy to any of the components (i.e. dyes, preservatives, fragrances, gluten)

☐ There is a commercially available product shortage or discontinuation by the manufacturer

attests that patient has had disease stabilization or improvement with the use of this compounded product

☐ None of the above

Q7. IF the request is for a compounded product, please specify if the unique dosage form is considered standard of care based on credible scientific literature defined as one of the following (Check all that apply):

☐ Peer reviewed literature indexed in Medline

☐ CMS recognized pharmacy compendia (e.g. NCCN, DrugDex, and AHFS DI)

☐ Published clinical practice guidelines developed by multidisciplinary experts and clinicians affected by the guidelines (e.g. American Medical Association, Infectious Disease Society of America)

☐ Other

☐ None of the above

Q8. If answer is OTHER, please specify below:

Q9. Coverage Policy: The Plan provides coverage only for medications that it defines or determines to be used for medically accepted indications. Elixir will approve requests based on the criteria outlined in this paragraph and the Plan's Benefit Design if the medication and quantity prescribed are covered by the plan and being used for a medically accepted indication. Medically accepted indications are defined by the plan as: Any use of a drug which is approved under the Food, Drug, and Cosmetic Act or supported by recognized compendia or resources.
Recognized compendia are: American Hospital Formulary Service Drug Information (AHFS), Micromedex, National Comprehensive Cancer Network (NCCN), and Clinical Pharmacology. When necessary, peer reviewed medical literature may also be used to determine medically accepted indications for anti-cancer chemotherapy requests. Acceptable peer-reviewed medical literature includes: American Journal of Medicine, Annals of Internal Medicine, Annals of Oncology, Annals of Surgical Oncology, Biology of Blood and Marrow Transplantation, Blood, Bone Marrow Transplantation, British Journal of Cancer, British Journal of Hematology, British Medical Journal, Cancer, Clinical Cancer Research, Drugs, European Journal of Cancer, Gynecologic Oncology, International Journal of Radiation, Oncology, Biology and Physics, The Journal of the American Medical Association, Journal of Clinical Oncology, Journal of the National Cancer Institute, Journal of the National Comprehensive Cancer Network, Journal of Urology, Lancet, Lancet Oncology, Leukemia, The New England Journal of Medicine, and Radiation Oncology. Articles published in these resources within the last 10 years will be accepted, however abstracts (including meeting abstracts) are excluded from consideration.

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Prescriber Signature

Date