COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Non Formulary Exception (NFE) Request-8A Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

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.

Drug Name and Strength:

Directions / SIG:

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard review timeframes (72 hours for initial requests or 7 days for appeals) may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

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

Q1. Is the drug being requested for initial therapy or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date:

Q3. What is the patient's diagnosis for the requested medication?

Q4. Does the patient reside in a Long Term Care Facility or at home?

☐ Long Term Care Facility
☐ Home residence
☐ None of the above

Q5. What is the anticipated duration of therapy?

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

Q6. If this medication is being given via the IV route of administration, which of the following apply:

☐ The medication is being given via an infusion pump
☐ The medication is being given via IV push or infusion drip (gravity method)

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Patient Name:	**Prescriber Name:**

☐ The medication is not being administered via the IV route, it is being used SQ or IM
☐ The medication is not being given via IV

Q7. If being given by an infusion pump, did Medicare pay for the pump?

☐ Yes ☐ No

Q8. Will this medication be administered with a nebulizer?

☐ Yes ☐ No

Q9. Are formulary alternatives contraindicated or not appropriate for this patient? Please provide details:

Q10. Two formulary alternatives are required in order for a non-formulary item to be approved. • Please list the formulary alternatives that the patient has tried for the requested diagnosis. • Include the date and response to therapy (i.e. ineffective, intolerance, contraindication, etc). • Without this information, this request will be denied.

Prescriber Signature

Date