COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tier Exception (TE)-4A 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 this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

Q4. Has the patient tried formulary alternatives to treat this diagnosis?

☐ Yes ☐ No

Q5. Please list all medications the patient has tried to treat this diagnosis:

Q6. Which of the following apply to the patient requesting the Tier Exception?

☐ The generic or preferred brand alternatives would not be as effective or have not been as effective to treat this diagnosis

☐ The patient was intolerant of the generic or preferred brand alternatives to treat this diagnosis

☐ The patient has a documented allergy to the generic or preferred brand alternatives to treat this diagnosis

☐ None of the above

Q7. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment

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failures, or any other additional clinical information to support a tier exception request)

Prescriber Signature

Date