COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Elixir DAW Penalty Form

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 indicate Start Date:

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

Q4. The Plan has a mandatory generic benefit design. When there is a generic available, the patient is required to pay the difference in cost between the brand and the generic medication unless there is a medical reason why the patient cannot use the generic medication. Is there any medical reason why the patient cannot use the generic version of this medication?

☐ Yes ☐ No

Q5. If there is NOT a medical reason why the patient cannot use the generic version of this medication, please indicate the reason that the brand name version is necessary.

☐ The Generic form of the drug is unavailable
☐ The Generic form of the drug has been recalled by the manufacturer
☐ The patient likes the brand drug
☐ It is acceptable for the patient to use the generic form of the drug

Q6. If there IS a medical reason why the patient cannot use the generic version of this drug, please explain below:

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Q7. If there IS a medical reason the patient cannot use the generic version of this drug, has a report of the adverse reaction or contraindication been filed with the FDA via the MedWatch Reporting Reporting Program at https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm? ☐ Yes ☐ No
Q8. If the patient has tried and failed a generic version of this medication in the past, please indicate below the date the generic was tried and failed:
Q9. Are there any additional circumstances that prevent patient from safely taking the generic alternative? If so, please elaborate below.

Prescriber Signature

Date