



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Market Priced Drug (MPD)-1c Request

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? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. Has the patient tried the therapeutic alternative? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Did the patient experience adverse effects that resulted in discontinuation of the therapeutic alternative? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is use of the therapeutic alternative contraindicated with other medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Please specify reason therapeutic alternative is contraindicated with other medications:
Q8. Did the patient fail to achieve the therapy goal after an adequate trial of the therapeutic alternative? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Market Priced Drug (MPD)-1c Request

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:

Q9. Please provide any additional information to be considered and used in determination of this exception:

Prescriber Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document