COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Quantity Limit Exception (QLE)-4A Medicare

Phone: 833-674-6200 (option 3) 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. How many units does the patient require PER MONTH (if the request is for less than a one month supply please provide quantity requested with day supply and/or directions for use)?

Q5. If the dose can be consolidated using a higher strength commercially available product, please provide details why this is not appropriate for this patient:

Q6. Prescriber may provide any additional rationale or details why this patient requires a quantity above the plan limit (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request):

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date