

PHARMACY COVERAGE DETERMINATION REQUEST FORM

Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Member ID#		Prescriber Address	
Sex (circle) M F		NPI#(required)	
DOB		Office Phone	
Home Phone:		Office Fax	
		Contact Person	
Diagnosis and Medical Information			
Medication	Strength	Route of Administration	Frequency
<input type="checkbox"/> New Prescription OR Date Therapy Began		Expected Length of Therapy	Qty
Height/Weight	Allergies	Diagnosis	ICD9 Code
PRESCRIBER'S SIGNATURE			Date
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION BELOW			
Rationale for Exception Request or Prior Authorization			
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure). Specify: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);			
<input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. Specify: Anticipated significant adverse clinical outcome;			
<input type="checkbox"/> Medical need for different dosage form and/or higher dosage; Specify: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason;			
Other: _____ Explain below			
Required Explanation			