ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Atypical Antipsychotics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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 Envision 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 specify start date (MM/YY):

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

☐ Bipolar I disorder ☐ Schizophrenia ☐ Other

Q4. If the diagnosis is OTHER, please specify below:

Q5. Has the patient tried and failed any of the following (please select all that apply)?

☐ Aripiprazole
☐ Clozapine
☐ Olanzapine
☐ Olanzapine-Fluoxetine
☐ Paliperidone
☐ Quetiapine
☐ Risperidone
☐ Ziprasidone
☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

☐ Yes (Please explain): ☐ No

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
GLP1-Insulin-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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.**

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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):	

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☐ 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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Diabetes Type 2 ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient tried and failed any of the following (please select all that apply)?

☐ Lantus
☐ Levemir
☐ Ozempic
☐ Toujeo
☐ Tresiba
☐ Victoza
☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

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GLP1-Insulin-3 Medicare

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Please explain why the patient is unable to use the medications listed in the previous questions:	

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
PPI-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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):	

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☐ 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 specify start date (MM/YY):

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

☐ Erosive esophagitis
☐ Gastroesophageal reflux disease (GERD)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient tried and failed any of the following? (please select all that apply)

☐ Lansoprazole
☐ Omeprazole
☐ Pantoprazole
☐ Rabeprazole
☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

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PPI-1 Medicare

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trelegy-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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 Envision 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:

☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below.

Q5. Does the patient have a history of failure, contraindication, or intolerance to any of the following formulary alternatives?

- ☐ Advair Diskus
- ☐ Breo Ellipta
- ☐ Serevent Diskus
- ☐ Spiriva HandiHaler
- ☐ Spiriva Respimat
- ☐ Stiolto
- ☐ None of the above

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Trelegy-5 Medicare

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Patient Name:	**Prescriber Name:**

Q6. If the patient has NOT tried any of the above medications, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trintellix-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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 Envision 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 the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the diagnosis for which the medication is being requested:

☐ Major depressive disorder ☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Has the patient tried TWO (2) generic formulary antidepressants (e.g. amitriptyline, amoxapine, bupropion, citalopram, clomipramine, desipramine, desvenlafaxine, doxepin, duloxetine, escitalopram, fluoxetine, fluvoxamine, imipramine, maprotiline, mirtazapine, nefazodone, nortriptyline, paroxetine, phenelzine, protriptyline, sertraline, tranylcypromine, trazodone, venlafaxine)?

☐ Yes ☐ No

Q6. If the patient has NOT tried 2 generic formulary antidepressants, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Q7. Please list which generic antidepressant medications the patient has previously tried and failed:

COVERAGE DETERMINATION REQUEST FORM

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Trintellix-1 Medicare

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Uloric-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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.**

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Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
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☐ 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 (MM/YY):

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

☐ Gout ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient tried and failed ALLOPURINOL?

☐ Yes ☐ No

Q6. If the patient has NOT tried ALLOPURINOL, please indicate the reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

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EOC ID:
Uloric-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date