COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Non Formulary Exception (NFE) Request-6A Medicare

Phone: 800-361-4542 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.

☐ 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 provide the patient's diagnosis for the requested medication:

Q4. What is the anticipated duration of therapy?

☐ Less than a month
☐ One to three months
☐ Three months to one year
☐ Lifetime

Q5. Has the patient tried any other medications in the same therapeutic class/category for the requested diagnosis?

☐ Yes ☐ No

Q6. Please list all medications the patient has previously tried for the requested diagnosis along with the date and response to therapy (i.e. ineffective, adverse reaction, contraindication, etc):

Q7. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Non Formulary Exception (NFE) Request-6A Medicare

Phone: 800-361-4542 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:**

Q8. Does the patient reside in a Long Term Care (LTC) Facility or at home?

- ☐ Long Term Care (LTC) Facility
- ☐ Home residence
- ☐ None of the above

Q9. If the medication is being given via the IV route of administration, which of the following apply:

- ☐ The medication is being given via an infusion pump
- ☐ The medication is being given via IV push or infusion drip (gravity method)
- ☐ The medication is not being administered via the IV route, it is being used SQ or IM
- ☐ The medication is not being given via IV

Q10. If being given by an infusion pump, did Medicare pay for the pump?

- ☐ Yes
- ☐ No
- ☐ Medication does not require an infusion pump

Q11. Will this medication be administered with a nebulizer?

- ☐ Yes
- ☐ No

Prescriber Signature

Date