COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Quantity Limit Exception (QLE)-1 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:

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 member 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):

Prescriber Signature

Date

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