COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tier Exception (TE)-3 Medicare

Phone: 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. Please provide the patient's diagnosis for the requested medication:
Q3. Please list all medications that were tried and failed for the submitted diagnosis:
Q4. If formulary alternatives not listed in the previous question are contraindicated or not appropriate, provide reason(s) why.

Prescriber Signature _____ Date _____