



Return completed request and Medical Record documentation to:
 Fax: 800-953-8856
 If you have any questions, call:
 Phone: 800-953-8854

MEDICAL RX COVERAGE DETERMINATION REQUEST FORM

Patient Name			Prescriber Name		
Member ID #			Prescriber NPI#	Tax ID Number	
Sex (circle)	M	F	DOB	Office Phone	Office Fax
Height	Weight	Allergies		Servicing Provider (if applicable)	
Contact Person			Servicing Provider NPI#		
Medication, Strength, & Dose			Route of Admin.	Directions	
<input type="checkbox"/> New Therapy: Date to Start: _____ <input type="checkbox"/> Continuation: Date Began: _____				Expected Length of Therapy	
Diagnosis for Medication Treatment			ICD10 Code	HPCS/J Code	
PRESCRIBER'S SIGNATURE (Required)				Date	
<p><u>This section must be completed.</u> Incorrect completion may result in delays in reimbursement or provision of service.</p> <p><input type="checkbox"/> The medical benefit ("Buy and Bill"). J-CODE: _____ Total Billable Units: _____</p> <p style="text-align: center;">-</p>					
<p>Rationale for Exception Request or Prior Authorization (Must attach supporting clinical notes)</p> <p><input type="checkbox"/> Alternate covered drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) and completed MedWatch Form. Specify: (1) Covered drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each;</p> <p>_____</p> <p><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: (1) Anticipated significant adverse clinical outcome(s) below;</p> <p><input type="checkbox"/> Medical need for different dosage form and/or higher dosage; Specify: (1) New dosage form; (2) Dosage tried; (3) Documented medical reason</p> <p><input type="checkbox"/> Other: _____ (Explain below)</p>					
Required Explanation:					

Disclaimer:
 This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.