COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Elixir On-Line Prior Authorization Form

Phone: 800-361-4542 Fax back to: 866-414-3453

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 request for initial or continuing therapy?

☐ Initial ☐ Continuing

Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):

Q3. Please indicate the patient's diagnosis below.

Q4. Have other formulary alternatives in this drug category/class been tried and failed?

☐ Yes ☐ No

Q5. Please list them below along with the date the medication was tried and failed.

Q6. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having?

☐ The patient has an allergy to the formulary alternative ☐ Other

Q7. If Other, please describe below:

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

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