COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Non Formulary Exception (NFE) Request-8A Medicare

Phone: 866-250-2005 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 indicate the patient's diagnosis for the requested medication:

Q3. Where does the patient reside?

☐ Long Term Care/Intermediate Care Facility
☐ Home residence
☐ None of the above

Q4. If this 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
☐ Not Applicable -The medication is not being given via injection

Q5. If being given by an infusion pump, did Medicare pay for the pump?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Will this medication be administered with a nebulizer?

☐ Yes ☐ No

Q7. Please list all medications that were tried and failed for the submitted diagnosis and REASON FOR THERAPY FAILURE (i.e. ineffective, intolerance, adverse reaction, etc.).

Q8. If formulary alternatives not listed in previous question are contraindicated or not appropriate, provide reason(s) why.

Prescriber Signature

Date