COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Elixir Non Formulary Exception (NFE) Request

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 this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please provide the patient's diagnosis for the requested medication:

Q4. Please list all medications the patient has previously tried for the requested diagnosis along with the date and response to therapy (i.e. ineffective, adverse reaction, contraindication, etc):

Q5. If the patient has not tried any formulary alternatives, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)? Please specify:

Q6. Please check all that apply to this patient:

☐ Patient has an allergy to all formulary alternatives

☐ Patient has a contraindication (reason not to take) or drug-to-drug interaction to all formulary alternatives

☐ Patient has a history of unacceptable or toxic side effects to all formulary alternatives

☐ Patient has an indication (a medical condition) that is unique to a non-preferred drug and is supported by a compendia or a unique federal Food and Drug Administration approved indication (medical condition)

☐ Patient has an age-specific indication (medical

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☐ Patient has had therapeutic failure (poor response with) to all formulary alternatives

☐ Patient has a history of unacceptable or toxic side effects to all formulary alternatives on the preferred drug list

condition), medical co-morbidity (having more than one medical condition at the same time), or other medical complication that precludes the use of a preferred drug

☐ There is a clinically unacceptable risk with a change in therapy to a preferred drug

☐ None of the above

Prescriber Signature

Date