



**COVERAGE DETERMINATION REQUEST FORM**

**EOC ID:**  
Medicare Prior Authorization Request

**Phone: 833-674-6200 (option 3) 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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
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.**

Drug Name and Strength:	<input type="checkbox"/> <b>REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard review timeframes (72 hours for initial requests or 7 days for appeals) may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.</b>
Directions / SIG:	

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please provide the patient's diagnosis for the requested medication below:</p>
<p>Q4. What is the quantity of medication that is being requested per 30 days?</p>
<p>Q5. What is the anticipated duration of therapy?</p> <p><input type="checkbox"/> Less than one month  <input type="checkbox"/> One to three months  <input type="checkbox"/> Three months to one year  <input type="checkbox"/> Lifetime</p>
<p>Q6. Please list all medications the patient has previously tried for the requested diagnosis below, along with the dates and outcomes, including response to therapy (i.e. ineffective, adverse reaction, contraindication, etc):</p>



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Patient Name:

Prescriber Name:

Prescriber Signature

Date

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