COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Abiraterone-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Metastatic prostate cancer, castration-resistant
☐ Metastatic prostate cancer, high-risk, castration-sensitive
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. Is the requested medication being used in combination with prednisone?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist or urologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Abiraterone-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Actimmune-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic granulomatous disease
☐ Severe malignant osteopetrosis (SMO)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For CHRONIC GRANULOMATOUS DISEASE, will the requested medication be used to reduce the frequency and severity of serious infections?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Actimmune-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adempas-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic thromboembolic pulmonary hypertension (CTEPH), World Health Organization group 4
☐ Pulmonary arterial hypertension (PAH), World Health Organization group 1
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For CTEPH, please select all that apply to the patient:

☐ Patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy)
☐ Patient's disease is inoperable
☐ None of the above

Q6. For PAH, was the diagnosis confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adempas-2 Medicare

Phone: 800-361-4542 **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:**

Q7. For FEMALE PATIENTS, is the patient enrolled in the Adempas REMS program?

☐ Yes ☐ No ☐ Not applicable

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?

☐ Yes ☐ No

Q10. Does the patient have any of the following (please select all that apply)?

☐ Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form

☐ Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline)

☐ Pregnancy

☐ Pulmonary hypertension associated with idiopathic interstitial pneumonia

☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Afinitor Disperz-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Tuberous sclerosis complex (TSC)-associated partial-onset seizures
☐ Subependymal giant cell astrocytoma (SEGA) associated with TSC
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For SEGA ASSOCIATED WITH TSC, is the patient a candidate for curative surgical resection?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by, or in consultation with, an oncologist or neurologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Afinitor Disperz-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alecensa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive as detected by a FDA-approved test?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alecensa-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alkindi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Adrenocortical insufficiency ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient require dosages not available with other available formulations of hydrocortisone?

☐ Yes ☐ No

Q6. If the patient has NOT tried other available formulations of hydrocortisone, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Is the patient 18 years of age or younger?

☐ Yes ☐ No

Q8. Is the requested medication being prescribed by or in conjunction with an endocrinologist or pediatrician?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alkindi-1 Medicare

Phone: 800-361-4542 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:**

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Alpha-1 Proteinase Inhibitor-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Alpha-1 proteinase inhibitor (alpha-1-antitrypsin) deficiency ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have emphysema?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q8. Does the patient reside in a long-term care (LTC) or hospital setting?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Alpha-1 Proteinase Inhibitor-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes	☐ No
Q9. Is the medication being given via an infusion pump?	
☐ Yes	☐ No
Q10. Did Medicare pay for the infusion pump?	
☐ Yes ☐ No ☐ N/A - the medication is not being given via an infusion pump	

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alunbrig-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alunbrig-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alyq-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Was the patient's diagnosis confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Will the patient be concurrently using organic nitrates or guanylate cyclase stimulators (includes intermittent use)?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alyq-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ambrisentan-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH), World Health Organization group 1 ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Was the diagnosis confirmed by right heart catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ambrisentan-2 Medicare

Phone: 800-361-4542 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:**

Q8. Does the patient have any of the following? (Please select all that apply.)

- ☐ Pregnancy
- ☐ Idiopathic pulmonary fibrosis (IPF), including those with pulmonary hypertension
- ☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Amphetamines-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate which medication is being requested:

☐ Amphetamine-dextroamphetamine ER
☐ Dextroamphetamine ER
☐ Dextroamphetamine IR
☐ Vyvanse

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Attention Deficit Hyperactivity disorder (ADHD)
☐ Narcolepsy
☐ Other

Q5. If the patient’s diagnosis is OTHER, please specify below:

Q6. For NARCOLEPSY, has the diagnosis been confirmed by a sleep study?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Amphetamines-1 Medicare

Phone: 800-361-4542 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:**

Q7. Please provide justification if a sleep study would not be feasible:

Q8. Please select all that apply to the patient:

☐ The patient will not be concomitantly using the requested medication with MAOIs or will not use within 14 days of MAOI administration

☐ The prescriber is a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs

☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arcalyst-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cryopyrin-associated periodic syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 12 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary Mycobacterium avium complex (MAC) infection ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication being used as part of a combination antibacterial regimen in a treatment refractory patient?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an infectious disease specialist or pulmonologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Auryxia-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Hyperphosphatemia ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have chronic kidney disease (CKD)?
☐ Yes ☐ No

Q6. Is the patient on dialysis?
☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with a hematologist or nephrologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Auryxia-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

Q9. Does the patient have iron overload syndrome (e.g., hemochromatosis)?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Austedo-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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):	

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☐ 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 indicate the patient's diagnosis for the requested medication:

☐ Chorea associated with Huntington's disease (Huntington's chorea)
☐ Tardive dyskinesia
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with a neurologist or psychiatrist?

☐ Yes ☐ No

Q7. Does the patient have any of the following (please select all that apply)?

☐ Hepatic impairment
☐ Suicidal ideation

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Austedo-1 Medicare

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Patient Name:	**Prescriber Name:**

☐ Untreated or inadequately treated depression
☐ None of the above

Q8. Is the patient taking MAOIs, reserpine, or tetrabenazine?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ayvakit-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Gastrointestinal stromal tumor, unresectable or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is there presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ayvakit-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Balversa-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Urothelial carcinoma, locally advanced or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient has susceptible FGFR3 or FGFR2 genetic alterations

☐ The patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy

☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist or urologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Balversa-2 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosentan-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension, World Health Organization (WHO) group 1 ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have New York Heart Association (NYHA) Functional Class II-IV symptoms?

☐ Yes ☐ No

Q6. Was the diagnosis confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosentan-2 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

Q8. Does the patient have any of the following? (Please select all that apply.)

- ☐ Concomitant use of cyclosporine A or glyburide therapy
- ☐ Pregnancy
- ☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosulif-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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):	

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☐ 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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient's disease is in the chronic, accelerated, or blast phase
☐ The patient's disease is newly diagnosed chronic phase
☐ The patient has resistance or an inadequate response to prior therapy
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by or in consultation with an oncologist?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosulif-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Colorectal cancer, metastatic
☐ Melanoma, unresectable or metastatic
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For COLORECTAL CANCER, please select all that apply to the patient:

☐ The patient has documented BRAF V600E mutation as detected by a FDA-approved test
☐ The patient has received prior therapy
☐ The requested medication will be used in combination with cetuximab (Erbitux)
☐ None of the above

Q6. For MELANOMA, please select all that apply to the patient:

☐ The patient has documented BRAF V600E or V600K mutation as detected by a FDA-approved test
☐ The requested medication will be used in combination with binimetinib (Mektovi)

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-1 Medicare

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Patient Name:	**Prescriber Name:**

☐ None of the above

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Brukinsa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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):	

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☐ 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 indicate the patient's diagnosis for the requested medication:

☐ Mantle cell lymphoma (MCL) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient tried one prior therapy?

☐ Yes ☐ No

Q6. If the patient has NOT tried any prior therapies, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Brukinsa-1 Medicare

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Patient Name:	**Prescriber Name:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cablivi-1 Medicare

Phone: 800-361-4542 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):	

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☐ 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 indicate the patient's diagnosis for the requested medication:
☐ Acquired thrombotic thrombocytopenic purpura (aTTP) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication being used in combination with plasma exchange and immunosuppression therapy?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cablivi-1 Medicare

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Patient Name:	**Prescriber Name:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabometyx-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Renal cell carcinoma, advanced
☐ Hepatocellular carcinoma, advanced
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For HEPATOCELLULAR CARCINOMA, has the patient been previously treated with sorafenib (Nexavar)?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Cabometyx-1 Medicare

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Patient Name:	**Prescriber Name:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Calquence-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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):	

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☐ 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 indicate the patient's diagnosis for the requested medication:

☐ Chronic lymphocytic leukemia (CLL)
☐ Mantle cell lymphoma (MCL)
☐ Small lymphocytic lymphoma (SLL)
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For MANTLE CELL LYMPHOMA, has the patient tried at least one other therapy?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Calquence-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Caprelsa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Medullary thyroid cancer (MTC) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease metastatic or unresectable, locally advanced?
☐ Yes ☐ No

Q6. Is the patient's disease symptomatic or progressive?
☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q8. Does the patient have congenital long QT syndrome?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Caprelsa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cayston-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Cystic fibrosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Was the patient's diagnosis confirmed by appropriate diagnostic or genetic testing?
☐ Yes ☐ No

Q6. Does the patient have suspected or confirmed Pseudomonas aeruginosa infection?
☐ Yes ☐ No

Q7. Is the patient 7 years of age or older?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cayston-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cinryze-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hereditary angioedema (HAE) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The requested medication is being used in prevention of angioedema attacks
☐ The requested medication is being used in prevention of acute abdominal, facial, or laryngeal attacks
☐ None of the above

Q6. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a hematologist, immunologist, or allergist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cinryze-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
CNS Stimulants-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Narcolepsy
☐ Obstructive sleep apnea (OSA)
☐ Shift work disorder (SWD)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For NARCOLEPSY or OBSTRUCTIVE SLEEP APNEA, was the patient's diagnosis confirmed by sleep lab evaluation?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
CNS Stimulants-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cometriq-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Medullary thyroid cancer (progressive, metastatic) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Copiktra-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic lymphocytic leukemia
☐ Follicular lymphoma
☐ Small lymphocytic lymphoma
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease relapsed or refractory?

☐ Yes ☐ No

Q6. Does the patient have a history of at least two prior therapies?

☐ Yes ☐ No

Q7. If the patient has NOT tried two prior therapies, is there a reason why (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Copiktra-1 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Stable, symptomatic chronic heart failure
☐ Stable, symptomatic heart failure due to dilated cardiomyopathy
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For CHRONIC HEART FAILURE, please select all that apply to the patient:

☐ The patient has a left ventricular ejection fraction (LVEF) 35% or less
☐ The patient is in sinus rhythm with resting heart rate 70 beats per minute or more
☐ The patient is on maximally tolerated doses of beta blockers
☐ The patient has a contraindication to beta blocker use
☐ None of the above

Q6. For HEART FAILURE DUE TO DILATED CARDIOMYOPATHY, is the patient in sinus rhythm with an elevated heart rate?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes ☐ No

Q7. Does the patient have any of the following? (Please select all that apply.)

- ☐ Bradycardia (i.e., resting heart rate is less than 60 beats per minute prior to treatment)
- ☐ Decompensated acute heart failure
- ☐ Hypotension (i.e., blood pressure less than 90/50 mmHg)
- ☐ Severe hepatic impairment (Child-Pugh C)
- ☐ Sick sinus syndrome, sinoatrial block, or 3rd degree AV block (unless a functioning demand pacemaker is present)
- ☐ None of the above

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-3 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Ankylosing spondylitis
☐ Non-radiographic axial spondyloarthritis
☐ Plaque psoriasis, moderate to severe
☐ Psoriatic arthritis, active
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient failed or is intolerant to any of the following? (Please select all that apply.)

☐ Humira ☐ Enbrel ☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Was the patient screened for latent tuberculosis prior to initiation of treatment?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-3 Medicare

Phone: 800-361-4542 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:**

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please indicate the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Malignant melanoma, unresectable or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have BRAF V600E or V600K mutation?
☐ Yes ☐ No

Q6. Is the requested medication being used in combination with vemurafenib (Zelboraf)?
☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-2 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystinosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have corneal cystine crystal accumulation?

☐ Yes ☐ No

Q6. Does the patient have demonstrated hypersensitivity to cysteamine or penicillamine?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-2 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dalfampridine-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Multiple sclerosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient demonstrated sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting the requested medication?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q8. Does the patient have any of the following? (Please select all that apply.)

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Dalfampridine-1 Medicare

Phone: 800-361-4542 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:**

- ☐ History of seizure
- ☐ Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute)
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Daurismo-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Acute myeloid leukemia (AML), newly diagnosed ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication being used in combination with cytarabine?
☐ Yes ☐ No

Q6. Is the patient 75 years of age or older?
☐ Yes ☐ No

Q7. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy?
☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Daurismo-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Deferasirox-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic iron overload due to blood transfusions (transfusion hemosiderosis)
☐ Chronic iron overload in non-transfusion-dependent thalassemia syndromes
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS, please select all that apply to the patient:

☐ The patient has had transfusion of at least 100 mL/kg packed red blood cells
☐ The patient has serum ferritin level greater than 1000 mcg/L
☐ None of the above

Q6. For CHRONIC IRON OVERLOAD IN NON-TRANSFUSION-DEPENDENT THALASSEMIA SYNDROMES, please select all that apply to the patient:

☐ The patient has liver iron concentrations of at least 5 mg Fe/g dry weight
☐ The patient has serum ferritin level greater than 300 mcg/L

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Deferasirox-1 Medicare

Phone: 800-361-4542 **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:**

☐ None of the above

Q7. Does the patient have any of the following? (Please select all that apply.)

- ☐ Advanced malignancy
- ☐ Creatinine clearance less than 40 mL/min
- ☐ High risk myelodysplastic syndrome (MDS)
- ☐ Platelet count less than 50 x 10(9)/L
- ☐ Poor performance status
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Diacomit-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Severe myoclonic epilepsy in infancy (Dravet syndrome) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient taking clobazam?

☐ Yes ☐ No

Q6. Is the requested medication being prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Diacomit-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Diclofenac Topical-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Actinic keratosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dojolvi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Long-chain fatty acid oxidation disorder (LC-FAOD) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dronabinol-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Anorexia associated to AIDS
☐ Chemotherapy-induced nausea and vomiting
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have sesame oil hypersensitivity?

☐ Yes ☐ No

Q6. Is the oral anti-nausea drug being used as part of an anti-cancer chemotherapeutic regimen?

☐ Yes ☐ No

Q7. Is the oral drug being used as a full therapeutic replacement for an intravenous anti-nausea drug administered within 48 hours of chemotherapy?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Dronabinol-2 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dupixent-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Asthma, moderate to severe
☐ Atopic dermatitis, moderate to severe
☐ Chronic rhinosinusitis with nasal polyposis
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For ASTHMA, please select all that apply to this patient:

☐ The patient's asthma has an eosinophilic phenotype
☐ The patient's asthma is oral corticosteroid-dependent
☐ None of the above

Q6. For ASTHMA or RHINOSINUSITIS, is the requested medication being used as adjunct treatment?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dupixent-1 Medicare

Phone: 800-361-4542 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:**

Q7. For ATOPIC DERMATITIS, has the patient had trial and failure, contraindication, or intolerance to two medium to high potency topical corticosteroids (e.g., mometasone, triamcinolone, fluocinolone, betamethasone, etc.)?

☐ Yes ☐ No

Q8. If the patient has NOT tried any topical corticosteroids, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q9. Is the requested medication prescribed by or in consultation with an allergist, dermatologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

- ☐ Ankylosing spondylitis
- ☐ Plaque psoriasis, moderate to severe chronic
- ☐ Polyarticular juvenile idiopathic arthritis, moderate to severe
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis, moderate to severe
- ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For PLAQUE PSORIASIS, is the patient a candidate for systemic therapy (such as the requested medication) or phototherapy?

☐ Yes ☐ No

Q6. Has the patient been screened for latent tuberculosis infection prior to initiation of treatment?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-2 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Endari-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute sickle cell disease
☐ Short bowel syndrome
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For SHORT BOWEL SYNDROME, is the requested medication being used in combination with recombinant human growth hormone?

☐ Yes ☐ No

Q6. Is the patient 5 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Endari-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enspryng-3 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Neuromyelitis optica spectrum disorder (NMOSD) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient anti-aquaporin-4 (AQP4) antibody positive?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a neurologist, immunologist, or ophthalmologist?
☐ Yes ☐ No

Q8. Does the patient have any of the following? (Please select all that apply.)

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enspryng-3 Medicare

Phone: 800-361-4542 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:**

- ☐ Active hepatitis B infection
- ☐ Active or untreated latent tuberculosis
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Entresto-3 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic heart failure
☐ Symptomatic heart failure
☐ Other

Q4. For CHRONIC HEART FAILURE, does the patient have New York Heart Association (NYHA) class II-IV heart failure?

☐ Yes ☐ No

Q5. For SYMPTOMATIC HEART FAILURE, does the patient have systemic left ventricular systolic dysfunction?

☐ Yes ☐ No

Q6. Does the patient have any of the following? (Please select all that apply.)

☐ History of angioedema related to previous ACE inhibitor or ARB therapy
☐ Concomitant use or use within 36 hours of an ACE inhibitor
☐ Concomitant use of aliskiren (Tekturna) in a patient with diabetes
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Entresto-3 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epidiolex-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Lennox-Gastaut syndrome
☐ Seizures associated with tuberous sclerosis complex
☐ Severe myoclonic epilepsy in infancy (Dravet syndrome)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epidiolex-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epoetin Therapy-2 Medicare

Phone: 800-361-4542 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 therapy or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Anemia associated with chronic kidney disease (CKD), on dialysis
☐ Anemia associated with chronic kidney disease (CKD), not on dialysis
☐ Anemia associated with myelosuppressive chemotherapy
☐ Anemia associated with zidovudine therapy in a patient with HIV infection
☐ Reduction of blood transfusions in a patient undergoing elective, non-cardiac, non-vascular surgery who is at high risk for perioperative blood loss
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's pre-treatment hemoglobin level less than 10 g/dL?

☐ Yes ☐ No

Q6. Will there be a dose reduction or interruption if hemoglobin exceeds one of the following: 10 g/dL (adult CKD not on dialysis, or cancer), 11 g/dL (CKD on dialysis), or 12 g/dL (pediatric CKD)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epoetin Therapy-2 Medicare

Phone: 800-361-4542 **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:**

☐ Yes
☐ No
☐ Not applicable - the patient has a different diagnosis

Q7. Does the patient have end stage renal disease?

☐ Yes ☐ No

Q8. Is the patient on dialysis?

☐ Yes ☐ No

Q9. Did the dialysis center receive a bundled payment for dialysis and dialysis medications?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erleada-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Metastatic, castration-sensitive prostate cancer
☐ Nonmetastatic, castration-resistant prostate cancer
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with an oncologist or urologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erleada-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erlotinib-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (locally advanced or metastatic)
☐ Pancreatic cancer (locally advanced, unresectable or metastatic)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For NON-SMALL CELL LUNG CANCER, please select all that apply to the patient:

☐ The patient has epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by a FDA-approved test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility
☐ The requested medication will be used as first-line treatment
☐ The patient had failure with at least one prior chemotherapy regimen
☐ The patient has no evidence of disease progression after four cycles of first-line platinum-based chemotherapy and the requested medication will be used as maintenance treatment
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erlotinib-1 Medicare

Phone: 800-361-4542 **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:**

Q6. For PANCREATIC CANCER, is the requested medication being used in combination with gemcitabine?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Everolimus-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Advanced hormone receptor-positive, human epidermal growth receptor 2 (HER2)-negative breast cancer
☐ Advanced renal cell carcinoma
☐ Progressive, well-differentiated, nonfunctional neuroendocrine tumors of gastrointestinal (GI) or lung origin, unresectable, locally advanced, or metastatic
☐ Pancreatic progressive neuroendocrine tumors, unresectable, locally advanced, or metastatic
☐ Renal angiomyolipoma and tuberous sclerosis complex (TSC) not requiring immediate surgery
☐ Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For BREAST CANCER, please select all that apply to the patient:

☐ Patient is postmenopausal
☐ The requested medication is being taken in combination with exemestane (Aromasin)
☐ Patient had failure with letrozole (Femara) or anastrozole (Arimidex)

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Everolimus-1 Medicare

Phone: 800-361-4542 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:**

☐ None of the above

Q6. For RENAL CELL CARCINOMA, has the patient had failure with sunitinib (Sutent) or sorafenib (Nexavar)?

☐ Yes ☐ No

Q7. If the patient has NOT tried any of the medications listed in the previous questions, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. For SEGA ASSOCIATED WITH TSC, is the patient a candidate for curative surgical resection?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist or neurologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Evrysdi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Spinal muscular atrophy (SMA) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Farydak-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Multiple myeloma ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication being used in combination with bortezomib (Velcade) and dexamethasone?

☐ Yes ☐ No

Q6. Has the patient received at least two prior treatment regimens, including bortezomib (Velcade) and an immunomodulatory agent [e.g., lenalidomide (Revlimid), thalidomide (Thalomid)]?

☐ Yes ☐ No

Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Farydak-2 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl Oral-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Cancer-related breakthrough pain ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient currently receiving or is tolerant to around-the-clock opioid therapy for persistent cancer pain?

☐ Yes ☐ No

Q6. Are the patient and prescriber enrolled in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation Mitigation Strategy (REMS) Access Program?

☐ Yes ☐ No

Q7. Is the patient 16 years of age or older?

☐ Yes ☐ No

Q8. Will the requested medication be used for any of the following? (Please select all that apply.)

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl Oral-1 Medicare

Phone: 800-361-4542 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:**

☐ Management of acute or postoperative pain (including headache/migraine, dental pain, or use in the emergency room)

☐ Use in an opioid non-tolerant patient

☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fintepla-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Severe myoclonic epilepsy in infancy (Dravet syndrome) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q6. Is the patient using the requested medication concomitantly with a monoamine oxidase inhibitor (MAOI) or within 14 days of discontinuing a MAOI?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fintepla-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firazyr-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Hereditary angioedema ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Will the requested medication be used for the treatment of acute attacks?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a hematologist, immunologist, or allergist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firazyr-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firdapse-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Lambert-Eaton myasthenic syndrome (LEMS) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Does the patient have a history of seizures?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firdapse-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fotivda-1 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Advanced renal cell cancer (RCC), relapsed or refractory ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient received 2 or more prior systemic therapies?

☐ Yes ☐ No

Q6. If the patient has NOT tried 2 or more prior systemic therapies, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fotivda-1 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:**

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Galafold-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Fabry disease ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have an amenable galactosidase alpha gene (GLA) mutation?
☐ Yes ☐ No

Q6. Is the patient 16 years of age or older?
☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Galafold-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gattex-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Short bowel syndrome ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient dependent on parenteral nutrition?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gavreto-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic, RET fusion-positive
☐ Medullary thyroid cancer (MTC), advanced or metastatic, RET-mutant
☐ Thyroid cancer, advanced or metastatic, RET fusion-positive
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. FOR NON-SMALL CELL LUNG CANCER, was the patient's diagnosis detected by a FDA-approved test?

☐ Yes ☐ No

Q6. FOR THYROID CANCER, please select all that apply to the patient:

☐ The patient requires systemic therapy (such as the requested medication)
☐ The patient is radioactive iodine-refractory, when radioactive iodine is appropriate
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gavreto-2 Medicare

Phone: 800-361-4542 **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:**

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gilotrif-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non–small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient's tumors have nonresistant epidermal growth factor receptor (EGFR) mutations as detected by a FDA-approved test

☐ The patient has squamous NSCLC with progression after platinum-based chemotherapy

☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gilotrif-2 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gocovri-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Extrapyramidal disease
☐ Parkinson's disease
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For PARKINSON'S DISEASE, please select all that apply to this patient:

☐ Patient is experiencing dyskinesia
☐ Patient is receiving levodopa-based therapy
☐ None of the above

Q6. Does the patient have a documented trial and failure of amantadine immediate release?

☐ Yes ☐ No

Q7. If the patient has NOT tried amantadine immediate release, is there a reason why this medication cannot be used

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gocovri-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

(i.e., contraindication, history of adverse event, etc.)?

Q8. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q9. Does the patient have end stage renal disease (ESRD, CrCl below 15 mL/min/m^2)?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic renal insufficiency (CRI), pediatric
☐ Growth hormone deficiency (GHD), adult
☐ Growth hormone deficiency (GHD), pediatric
☐ Idiopathic short stature, pediatric
☐ Noonan syndrome, pediatric
☐ Prader-Willi syndrome, pediatric
☐ Short-stature homeobox-containing gene (SHOX) deficiency, pediatric
☐ Small for gestational age (SGA), pediatric
☐ Turner syndrome
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For CHRONIC RENAL INSUFFICIENCY, please select all that apply to the patient:

☐ Nutritional status has been optimized
☐ Metabolic abnormalities have been corrected
☐ The patient has not had renal transplant
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

Phone: 800-361-4542 **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:**

Q6. For PEDIATRIC GROWTH HORMONE DEFICIENCY, please select all that apply to the patient:

- ☐ The patient's bone age is at least 1 year or 2 standard deviations (SD) delayed compared with chronological age
- ☐ The patient has 2 stimulation tests with peak growth hormone (GH) secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SD below mean if there is central nervous system (CNS) pathology, history of irradiation, or proven genetic cause
- ☐ None of the above

Q7. For PRADER-WILLI SYNDROME, was the diagnosis confirmed by genetic testing?

☐ Yes ☐ No

Q8. For SMALL FOR GESTATIONAL AGE, please select all that apply to the patient:

- ☐ The patient's birth weight or length is 2 or more standard deviations (SD) below mean for gestational age
- ☐ The patient failed to manifest catch up growth by age 2 (height 2 or more SD below mean for age and gender)
- ☐ None of the above

Q9. For TURNER SYNDROME, was the diagnosis confirmed by chromosome analysis?

☐ Yes ☐ No

Q10. For PEDIATRIC GROWTH HORMONE DEFICIENCY, CHRONIC RENAL INSUFFICIENCY, SHOX DEFICIENCY, NOONAN SYNDROME, OR PRADER-WILLI SYNDROME, please select all that apply to the patient:

- ☐ The patient's height is more than 3 standard deviations (SD) below mean for age and gender
- ☐ The patient's height is more than 2 SD below mean with growth velocity (GV) more than 1 SD below mean
- ☐ The patient's GV over 1 year is 2 SD below mean
- ☐ None of the above

Q11. For ADULT GROWTH HORMONE DEFICIENCY (GHD), please select all that apply to the patient:

- ☐ The patient has childhood or adult-onset GHD confirmed by 2 standard growth hormone (GH) stimulation tests
- ☐ The patient had an insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L)
- ☐ Insulin tolerance tests are contraindicated, and the patient had a standardized stimulation test (such as arginine plus GH releasing hormone [preferred], glucagon, arginine)
- ☐ The patient has at least 1 other pituitary hormone deficiency and failed at least 1 GH stimulation test (ITT preferred)
- ☐ The patient has panhypopituitarism (3 or more pituitary hormone deficiencies)
- ☐ The patient has irreversible hypothalamic-pituitary
- ☐ The patient has a subnormal IGF-1 (after at least 1 month off GH therapy)
- ☐ The patient has objective evidence of GHD complications, such as low bone density, increased visceral fat mass, or cardiovascular complications
- ☐ The patient has completed linear growth (growth velocity [GV] less than 2 cm/year)
- ☐ Growth hormone has been discontinued for at least 1 month (if previously receiving GH)
- ☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

Phone: 800-361-4542 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:**

structural lesions due to tumors, surgery, or radiation of pituitary or hypothalamus region

Q12. For ADULT GROWTH HORMONE DEFICIENCY, please provide the growth hormone (GH) stimulation tests that the patient underwent below.

Q13. Is the requested medication prescribed by or in consultation with an endocrinologist or nephrologist?

☐ Yes ☐ No

Q14. Does the patient have any of the following? (Please select all that apply.)

☐ The requested medication is being used for growth promotion in pediatric patients with closed epiphyses

☐ Acute critical illness caused by complications following open-heart or abdominal surgery, multiple accidental trauma, or acute respiratory failure

☐ Active malignancy

☐ Active proliferative or severe non-proliferative diabetic retinopathy

☐ Prader-Willi Syndrome in patients who are severely obese, have a history of upper airway obstruction or sleep apnea, or have severe respiratory impairment

☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepatitis C-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic Hepatitis C ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please provide the patient's genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy:

Q6. Has the prescriber documented the following within 12 weeks of initiating therapy: CBC, INR, hepatic function panel, and GFR?

☐ Yes ☐ No

Q7. Is the patient post-transplant?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Hepatitis C-1 Medicare

Phone: 800-361-4542 **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:**

Q8. What is the patient's cirrhosis status?

Q9. What is the patient's prior treatment history (if any)?

Q10. What is the patient's planned duration of treatment?

Q11. Is the requested medication prescribed by, or in consultation with, one of the following (please select any that apply)?

- ☐ Gastroenterologist
- ☐ Hepatologist
- ☐ Infectious Disease Specialist
- ☐ None of the above

Q12. For Vosevi: Has the patient had trial and failure, contraindication, or intolerance to Mavyret or Sofosbuvir/Velpatasvir (Epclusa)?

☐ Yes ☐ No ☐ N/A

Q13. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hetlioz-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-24-hour-sleep-wake disorder (Non-24)
☐ Nighttime sleep disturbances associated with Smith-Magenis Syndrome (SMS)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Muscle Relaxants-3 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute painful musculoskeletal conditions ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 65 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Ankylosing spondylitis
☐ Crohn's disease, moderate to severe
☐ Hidradenitis suppurativa, moderate to severe
☐ Non-infectious uveitis (including intermediate, posterior, and panuveitis)
☐ Plaque psoriasis, moderate to severe chronic
☐ Polyarticular juvenile idiopathic arthritis, moderate to severe
☐ Psoriatic arthritis
☐ Rheumatoid arthritis, moderate to severe
☐ Ulcerative colitis, moderate to severe
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For CROHN'S DISEASE, has the patient had an inadequate response to conventional therapy?

☐ Yes ☐ No

Q6. For PLAQUE PSORIASIS, is the patient a candidate for systemic therapy or phototherapy, and are other systemic therapies medically less appropriate?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-2 Medicare

Phone: 800-361-4542 **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:**

Q7. For ULCERATIVE COLITIS, has the patient had an inadequate response to immunosuppressants (e.g., corticosteroids, azathioprine)?

☐ Yes ☐ No

Q8. If the patient has NOT tried any of the medications listed in the previous question(s), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q9. Has the patient been screened for latent tuberculosis infection prior to initiation of treatment?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ibrance-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer, advanced or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?

☐ Yes ☐ No

Q6. Please indicate how the requested medication will be used:

☐ In combination with an aromatase inhibitor in a postmenopausal woman or man
☐ In combination with fulvestrant (Faslodex) for disease progression following endocrine therapy
☐ None of the above

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ibrance-1 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iclusig-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic myeloid leukemia (CML), chronic, accelerated, or blast phase
☐ Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient T315I-positive?

☐ Yes ☐ No

Q6. Is no other tyrosine kinase inhibitor therapy indicated for the patient?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Iclusig-1 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Idhifa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Acute myeloid leukemia (AML), relapsed or refractory ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have an isocitrate dehydrogenase 2 mutation as detected by a FDA-approved test?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Idhifa-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Imbruvica-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic graft-versus-host disease (cGVHD)
☐ Chronic lymphocytic leukemia (CLL), with or without 17p deletion
☐ Mantle cell lymphoma (MCL)
☐ Marginal zone lymphoma
☐ Small lymphocytic lymphoma (SLL), with or without 17p deletion
☐ Waldenstrom macroglobulinemia
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For GRAFT-VERSUS-HOST DISEASE, has the patient failed at least one first-line corticosteroid therapy?

☐ Yes ☐ No

Q6. For MANTLE CELL LYMPHOMA, has the patient received at least one prior therapy?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Imbruvica-2 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

Q7. For MARGINAL ZONE LYMPHOMA, please select all that apply to the patient:

- ☐ Patient requires systemic therapy
- ☐ Patient has received at least one prior anti-CD20-based therapy
- ☐ None of the above

Q8. If the patient has NOT tried any of the medications listed in the previous question(s), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inbrija-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Parkinson's disease ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Will the requested medication be used concurrently with carbidopa/levodopa?
☐ Yes ☐ No

Q6. Has the patient tried and failed or has a contraindication to one generic formulary alternative?
☐ Yes ☐ No

Q7. If the patient has NOT tried one generic formulary alternative, is there a reason why it cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Is the patient 18 years old or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inbrija-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes ☐ No

Q9. Do any of the following apply to this patient? (Please select all that apply.)

- ☐ Concurrent use with nonselective monoamine oxidase inhibitor (MAOI) (e.g., phenelzine or tranylcypromine)
- ☐ Recent use (within 2 weeks) with a nonselective MAOI
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Increlex-1 Medicare

Phone: 800-361-4542 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 the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Treatment of growth failure in a pediatric patient ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have any of the following? (Please select all that apply.)

☐ Severe primary insulin-like growth factor-1 (IGF-1) deficiency
☐ Growth hormone (GH) gene deletion and the patient has developed neutralizing antibodies to GH
☐ None of the above

Q6. Please select any of the following that apply to the patient:

☐ The patient has active or suspected malignancy
☐ The requested medication will be used for growth promotion in a patient with closed epiphyses
☐ The requested medication will be administered intravenously
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Increlex-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inqovi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups

☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inqovi-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inrebic-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inrebic-2 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Intrarosa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Moderate to severe dyspareunia due to menopause
☐ Atrophic vaginitis due to menopause
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Does the patient have any of the following? (Please select all that apply.)

☐ Known or suspected estrogen-dependent neoplasia
☐ Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Intrarosa-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iressa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient's tumor have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility?

☐ Yes ☐ No

Q6. Is the requested medication being used as first-line treatment?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iressa-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Isturisa-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Cushing's disease ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is pituitary surgery not an option or has not been curative for the patient?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an endocrinologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Isturisa-2 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Itraconazole-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the drug that is being requested below:

☐ Itraconazole capsules ☐ Itraconazole solution

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Candidiasis (esophageal or oropharyngeal)
☐ Onychomycosis
☐ Systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis)
☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. For CANDIDIASIS, is the disease refractory to treatment with fluconazole?

☐ Yes ☐ No

Q7. If the patient has NOT tried fluconazole, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Itraconazole-1 Medicare

Phone: 800-361-4542 **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:**

Q8. For ONYCHOMYCOSIS, was the diagnosis confirmed by positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy?

☐ Yes ☐ No

Q9. Does the patient have any of the following? (Please select all that apply.)

☐ Ventricular dysfunction (e.g., congestive heart failure [CHF] or history of CHF)
☐ Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.)
☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
IVIG-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)
☐ Idiopathic or chronic immune thrombocytopenic purpura
☐ Motor neuropathy with multiple conduction block
☐ Prevention of bacterial infection in patients with hypogammaglobulinemia or recurrent bacterial infections with B-cell chronic lymphocytic leukemia (CLL)
☐ Prevention of coronary artery aneurysms associated with Kawasaki syndrome
☐ Primary humoral immunodeficiency (congenital agammaglobulinemia, severe combined immunodeficiency syndromes [SCIDS], common variable immunodeficiency, X-linked immunodeficiency, Wiskott-Aldrich syndrome)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have any of the following? (Please select all that apply.)

☐ History of anaphylaxis or severe systemic reaction to human immune globulin
☐ IgA deficiency with antibody formation and a history of hypersensitivity

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
IVIG-1 Medicare

Phone: 800-361-4542 **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:**

☐ None of the above

Q6. Does the patient have primary immune deficiency disease? (One of these ICD-10 codes: D80.0; D80.5; D83.8; D83.9; D82.0; D81.0; D81.1; D81.2; D81.89; D81.9; G11.3; D80.2; D80.3; D80.4; D80.6; D80.7; D81.5; D81.6; D81.7; D82.1; D82.4; D83.0; D83.1; D83.2)

☐ Yes ☐ No

Q7. Is the medication being administered in the patient's home?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Jakafi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute graft-versus-host disease
☐ Intermediate or high risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis
☐ Polycythemia vera
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For GRAFT-VERSUS-HOST DISEASE, is the disease refractory to steroid therapy?

☐ Yes ☐ No

Q6. For POLYCYTHEMIA VERA, has the patient had an inadequate response to or is intolerant to hydroxyurea?

☐ Yes ☐ No

Q7. If the patient has NOT tried hydroxyurea, is there a reason why this medication cannot be used (i.e.,

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Jakafi-1 Medicare

Phone: 800-361-4542 **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:**

contraindication, history of adverse event, etc.)?

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Juxtapid-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Homozygous familial hypercholesterolemia (HoFH) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient's diagnosis been confirmed by any of the following? (Please select all that apply.)

☐ Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (LDLRAP1 or ARH)
☐ The patient has untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL
☐ Xanthoma before 10 years of age
☐ Evidence of heterozygous familial hypercholesterolemia in both parents
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Juxtapid-2 Medicare

Phone: 800-361-4542 **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:**

Q7. Please select any of the following that apply to the patient:

☐ The patient has moderate or severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests

☐ The patient is pregnant

☐ The requested medication will be used concomitantly with strong or moderate CYP3A4 inhibitors

☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kalydeco-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystic fibrosis (CF) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with a pulmonologist or is the prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kalydeco-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kesimpta-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Relapsing forms of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS)
☐ Experienced a first clinical episode and has MRI features consistent with multiple sclerosis
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q7. Does the patient have active hepatitis B infection?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kesimpta-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kisqali-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate which medication this request is for below:

☐ Kisqali ☐ Kisqali Femara

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Breast cancer, advanced or metastatic ☐ Other

Q5. If the patient’s diagnosis is OTHER, please specify below:

Q6. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?

☐ Yes ☐ No

Q7. Please indicate the patient's menopause status:

☐ The patient is postmenopausal
☐ The patient is premenopausal or perimenopausal
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kisqali-1 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Q10. For KISQALI, will the requested medication be used in combination with any of the following?

☐ An aromatase inhibitor
☐ Fulvestrant
☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Korlym-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Endogenous Cushing's syndrome ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient has type 2 diabetes mellitus or glucose intolerance
☐ The requested medication is being used to control hyperglycemia secondary to hypercortisolism
☐ The patient has failed surgery
☐ The patient is not a candidate for surgery
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an endocrinologist?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Korlym-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes ☐ No

Q8. Does the patient have any of the following? (Please select all that apply.)

- ☐ Pregnancy
- ☐ Coadministration with simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges
- ☐ Concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses
- ☐ History of unexplained vaginal bleeding
- ☐ Endometrial hyperplasia with atypia or endometrial carcinoma
- ☐ None of the above

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Koselugo-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Neurofibromatosis type 1 (NF1) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have symptomatic, inoperable plexiform neurofibromas (PN)?
☐ Yes ☐ No

Q6. Is the patient between 2 to 17 years of age?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Koselugo-2 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Kuvan/Sapropterin-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lenvima-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Endometrial carcinoma, advanced
☐ Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer
☐ Renal cell carcinoma, advanced
☐ Unresectable hepatocellular carcinoma, first-line therapy
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For ENDOMETRIAL CARCINOMA, please select all that apply to this patient:

☐ The patient's disease is NOT microsatellite instability-high or mismatch repair deficient
☐ The requested medication will be used in combination with pembrolizumab (Keytruda)
☐ The patient's disease has progressed following prior systemic therapy
☐ The patient is not a candidate for curative surgery or radiation
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lenvima-1 Medicare

Phone: 800-361-4542 **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:**

Q6. For RENAL CELL CARCINOMA, please select all that apply to the patient:

- ☐ The requested medication will be used in combination with everolimus
- ☐ The patient has received at least one prior anti-angiogenic therapy
- ☐ None of the above

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leukine-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia, following completion of induction chemotherapy
☐ Allogeneic or autologous bone marrow transplant, delayed or failed engraftment
☐ Autologous peripheral blood progenitor cell transplant, mobilization of progenitor cells for collection by leukapheresis
☐ Autologous peripheral blood stem cell transplant, following myeloablative chemotherapy
☐ Hematopoietic subsyndrome of acute radiation syndrome (H-ARS)
☐ Myeloid reconstitution after autologous or allogeneic bone marrow transplant
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leukine-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leuprolide-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Anemia due to uterine leiomyomata (fibroids), preoperative
☐ Central precocious puberty (idiopathic or neurogenic) in children
☐ Endometriosis
☐ Prostate cancer, advanced or metastatic
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below.

Q5. For PROSTATE CANCER, has the patient failed or is intolerant to Eligard?

☐ Yes ☐ No

Q6. If the patient has NOT tried Eligard, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Will this medication be administered in a physician's office?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Leuprolide-2 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q8. Will the physician's office furnish the medication from their stock?	
☐ Yes	☐ No
Q9. Will the patient get the medication from a pharmacy?	
☐ Yes	☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lidocaine Patch-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please indicate the start date (MM/YY):

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

- ☐ Pain associated with cancer-related neuropathy
- ☐ Pain associated with diabetic peripheral neuropathy
- ☐ Postherpetic neuralgia
- ☐ Back pain
- ☐ Osteoarthritis of the knee or hip
- ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lonsurf-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Colorectal cancer, metastatic
☐ Gastric or gastroesophageal junction adenocarcinoma, metastatic
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For COLORECTAL CANCER, does the patient have RAS wild-type?

☐ Yes ☐ No

Q6. For COLORECTAL CANCER, has the patient been previously treated with any of the following? (Please select all that apply.)

☐ Anti-EGFR therapy
☐ Anti-VEGF therapy
☐ Fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lonsurf-1 Medicare

Phone: 800-361-4542 **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:**

Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. For GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA, has the patient been previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lorbrena-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive?

☐ Yes ☐ No

Q6. Has the patient had disease progression on any of the following for metastatic disease? (Please select all that apply.)

- ☐ Alectinib (Alecensa) as the first ALK inhibitor
- ☐ Ceritinib (Zykadia) as the first ALK inhibitor
- ☐ Crizotinib (Xalkori) and at least 1 other ALK inhibitor
- ☐ None of the above

Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lorbrena-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Q10. Will the requested medication be used concomitantly with strong CYP3A4 inducers?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupkynis-1 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. For CONTINUING THERAPY, please indicate the start date (MM/YY):

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

☐ Systemic lupus erythematosus (SLE) with active lupus nephritis (LN) Classes III, IV, V (alone or in combination) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. FOR INITIAL THERAPY, please select all that apply to the patient:

☐ Patient has a baseline renal function of 45 mL/min/1.73 m2 or greater

☐ The requested medication will be used in combination with a background immunosuppressive therapy regimen (e.g. mycophenolate, oral steroids, etc)

☐ None of the above

Q6. FOR CONTINUING THERAPY, please select all that apply to the patient:

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupkynis-1 Medicare

Phone: 866-250-2005 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

☐ The patient had improvement in urine protein to creatinine ratio (UPCR) (i.e. 0.5 mg/mg or less)
☐ The patient has an estimated glomerular filtration rate (eGFR) of 60 mL/min/1.73 m2 or greater, or there is no confirmed decrease from baseline in eGFR of greater than 20%
☐ None of the above

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q8. Is the requested medication being prescribed by or in consultation with a rheumatologist or nephrologist?
☐ Yes ☐ No

Q9. Is the requested medication being used concomitantly with strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)?
☐ Yes ☐ No

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lynparza-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Advanced ovarian cancer
☐ Breast cancer, metastatic
☐ Epithelial ovarian, fallopian tube, or primary peritoneal cancer
☐ Pancreatic adenocarcinoma, metastatic
☐ Prostate cancer, metastatic castration-resistant
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For ADVANCED OVARIAN CANCER, please select all that apply to this patient:

☐ The patient has known or suspected BRCA mutation as detected by a FDA-approved test
☐ The patient has trial and failure, contraindication, or intolerance to 3 or more prior lines of chemotherapy
☐ None of the above

Q6. For BREAST CANCER, please select all that apply to this patient:

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lynparza-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative
☐ The patient has deleterious or suspected deleterious germline BRCA mutation (gBRCAm)
☐ The patient has been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting
☐ None of the above

Q7. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, please select all that apply to this patient:

☐ The cancer is recurrent
☐ The cancer is advanced
☐ The requested medication is being used for maintenance treatment in a patient who is in complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin)
☐ The patient has deleterious or suspected deleterious germline or somatic BRCA mutation (gBRCAm or sBRCAm)
☐ The patient is in complete or partial response to first-line platinum-based chemotherapy
☐ The cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA-mutation, and/or genomic instability
☐ The requested medication is being used in combination with bevacizumab (Avastin) for maintenance treatment
☐ None of the above

Q8. For PANCREATIC ADENOCARCINOMA, please select all that apply to this patient:

☐ The patient has deleterious or suspected deleterious germline BRCA-mutation
☐ The patient's disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen
☐ None of the above

Q9. For PROSTATE CANCER, please select all that apply to this patient:

☐ The patient has deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutation
☐ The patient has progressed following prior treatment with enzalutamide (Xtandi) or abiraterone (Zytiga)
☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mayzent-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Relapsing forms of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient had history of or contraindication to any of the following? (Please select all that apply.)

☐ Avonex
☐ Betaseron
☐ Copaxone
☐ Gilenya
☐ Tecfidera
☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mayzent-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q9. Does the patient have any of the following? (Please select all that apply.)

☐ CYP2C9*3/*3 genotype

☐ In the last 6 months, has experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III-IV heart failure

☐ Presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless the patient has a functioning pacemaker

☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mekinist-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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):	

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☐ 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 indicate the patient's diagnosis for the requested medication:

☐ Anaplastic thyroid cancer, locally advanced or metastatic
☐ Malignant melanoma
☐ Non-small cell lung cancer, metastatic
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For ANAPLASTIC THYROID CANCER, does the patient have no locoregional treatment options?

☐ Yes ☐ No

Q6. For ANAPLASTIC THYROID CANCER OR NON-SMALL CELL LUNG CANCER, does the patient have BRAF V600E mutation?

☐ Yes ☐ No

Q7. For MALIGNANT MELANOMA, please select all that apply to this patient:

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mekinist-2 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

- ☐ The patient has BRAF V600E or V600K mutations
- ☐ The patient has lymph node involvement, following complete resection
- ☐ The patient's disease is unresectable or metastatic
- ☐ The requested medication will be used as monotherapy
- ☐ None of the above

Q8. Will the requested medication be used in combination with dabrafenib (Tafinlar)?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mektovi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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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 indicate the patient's diagnosis for the requested medication:
☐ Malignant melanoma, unresectable or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have documented BRAF V600E or V600K mutation as detected by a FDA-approved test?
☐ Yes ☐ No

Q6. Will the requested medication be used in combination with encorafenib (Braftovi)?
☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mektovi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Methylphenidates-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Attention deficit hyperactivity disorder (ADHD)
☐ Narcolepsy
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For NARCOLEPSY, please select all that apply:

☐ The diagnosis was confirmed by a sleep study
☐ A sleep study would not be feasible
☐ None of the above

Q6. If a sleep study is not feasible, please provide justification:

Q7. Does the patient have any of the following? (Please select all that apply.)

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Methylphenidates-1 Medicare

Phone: 800-361-4542 **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:**

- ☐ Symptoms of marked anxiety, tension, or agitation
- ☐ Glaucoma
- ☐ Family history/diagnosis of Tourette's syndrome or presence of motor tics
- ☐ Concurrent use with MAOIs
- ☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Miglustat-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Gaucher disease, type 1 (mild to moderate) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient a candidate for enzyme replacement therapy?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Miglustat-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Multiple Sclerosis-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the medication that is being requested:

☐ Avonex
☐ Betaseron
☐ Copaxone/Glatiramer
☐ Gilenya
☐ Tecfidera/Dimethyl Fumarate

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Relapsing forms of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS)
☐ First clinical episode and the patient has MRI features consistent with multiple sclerosis
☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Please indicate the patient's age:

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Multiple Sclerosis-1 Medicare

Phone: 800-361-4542 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:**

☐ Less than 10 years of age
☐ 10 to 17 years of age
☐ 18 years of age or older

Q7. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q8. For GILENYA, please select all that apply to the patient:

☐ Recent (within the last 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure

☐ History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless the patient has a pacemaker

☐ Baseline QTc interval greater than or equal to 500 milliseconds

☐ Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (such as quinidine, procainamide, amiodarone, or sotalol)

☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Natpara-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hypoparathyroidism ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Will the requested medication be used to control hypocalcemia?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Natpara-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nerlynx-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient has early stage HER2-positive breast cancer
☐ The requested medication is being used following adjuvant trastuzumab (Herceptin) therapy
☐ The patient has advanced or metastatic HER2-positive breast cancer
☐ The requested medication is being used in combination with capecitabine (Xeloda)
☐ The patient has received 2 or more prior anti-HER2-based regimens in the metastatic setting
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nerlynx-1 Medicare

Phone: 800-361-4542 **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:**

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nexavar-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Advanced renal cell carcinoma
☐ Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma
☐ Unresectable hepatocellular carcinoma
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For DIFFERENTIATED THYROID CARCINOMA, is the disease refractory to radioactive iodine treatment?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Does the patient have squamous cell lung cancer being treated with carboplatin and paclitaxel?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nexavar-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ninlaro-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Multiple myeloma ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below.

Q5. Will the requested medication be used in combination with lenalidomide (Revlimid) and dexamethasone?
☐ Yes ☐ No

Q6. Does the patient have a history of at least one prior therapy?
☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ninlaro-1 Medicare

Phone: 800-361-4542 **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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Neurogenic orthostatic hypotension (NOH) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient symptomatic?

☐ Yes ☐ No

Q6. Is the patient's diagnosis caused by one of the following? (Please select all that apply.)

☐ Primary autonomic failure (for example, Parkinson's disease, multiple system atrophy, pure autonomic failure)
☐ Dopamine beta-hydroxylase deficiency
☐ Non-diabetic autonomic neuropathy
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-2 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nubeqa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-metastatic, castration-resistant prostate cancer ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with an oncologist or urologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nubeqa-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Severe asthma with eosinophilic phenotype
☐ Eosinophilic granulomatosis with polyangiitis (EGPA)
☐ Hypereosinophilic syndrome
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. FOR HYPEREOSINOPHILIC SYNDROME, has the condition lasted at least 6 months without an identifiable non-hematologic secondary cause?

☐ Yes ☐ No

Q6. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with any of the following?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-1 Medicare

Phone: 800-361-4542 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:**

- ☐ Allergist
- ☐ Immunologist
- ☐ Pulmonologist
- ☐ Rheumatologist
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuedexta-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pseudobulbar affect (PBA) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q7. Does the patient have any of the following? (Please select all that apply.)

☐ History of prolonged QT interval, congenital long QT syndrome or Torsades de pointes
☐ Heart failure
☐ Complete AV block without an implanted pacemaker or high risk of complete AV block
☐ Concomitant use with quinidine, quinine, mefloquine, or drugs that prolong QT interval and are metabolized by

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Nuedexta-1 Medicare

Phone: 800-361-4542 **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:**

CYP2D6 (e.g., thioridazine, pimozide)

- ☐ Concomitant use with monoamine oxidase inhibitors (MAOIs) or within 14 days of MAOI therapy
- ☐ None of the above

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuplazid-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Parkinson's disease psychosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient experiencing hallucinations and/or delusions?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuplazid-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Octreotide-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acromegaly
☐ Metastatic carcinoid syndrome
☐ Vasoactive intestinal peptide-secreting tumor (VIPoma) with associated diarrhea
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For ACROMEGALY, has the patient had an inadequate response to or is ineligible for any of the following (please select all that apply)?

☐ Surgery
☐ Radiation
☐ Bromocriptine mesylate
☐ None of the above

Q6. If the patient has NOT tried any of the options listed in the previous question, is there a reason these options cannot be used (i.e., contraindication, history of adverse event, patient is not a candidate, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Octreotide-1 Medicare

Phone: 800-361-4542 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:**

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Odomzo-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Basal cell carcinoma of the skin, locally advanced ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select any of the following that applies to the patient:

☐ Cancer has recurred following surgery or radiation therapy
☐ The patient is not a candidate for surgery or radiation therapy
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the patient pregnant?

☐ Yes
☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Odomzo-1 Medicare

Phone: 800-361-4542 **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:**

☐ Not applicable - the patient is not of child-bearing potential

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Onureg-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia (AML) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication being used in the maintenance treatment for an adult patient who has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy?

☐ Yes ☐ No

Q6. Is the patient able to complete intensive curative therapy?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Onureg-1 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the requested medication being prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opsumit-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH), World Health Organization group I ☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. Was the diagnosis confirmed by right heart catheterization or doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e. g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opsumit-1 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the patient pregnant?

☐ Yes ☐ No ☐ Not applicable

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orilissa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Moderate to severe pain associated with endometriosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Does the patient have any of the following (please select all that apply)?

☐ Pregnancy
☐ Known osteoporosis
☐ Severe hepatic impairment
☐ Concurrent use of strong organic anion transporting polypeptide (OATP) 1B1 inhibitors
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orilissa-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orkambi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystic fibrosis (CF) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have documented homozygous F508del mutation as confirmed by a FDA-approved CF mutation test?

☐ Yes ☐ No

Q6. Is the medication prescribed by, or in consultation with, a pulmonologist or prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orkambi-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Osphena-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause
☐ Moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Does the patient have any of the following (please select all that apply)?

☐ Undiagnosed abnormal genital bleeding
☐ Known or suspected estrogen-dependent neoplasia
☐ Active deep vein thrombosis (DVT), pulmonary embolism (PE), or a history of these conditions
☐ Active arterial thromboembolic disease (eg. stroke, myocardial infarction) or a history of these conditions
☐ Pregnancy

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Osphena-1 Medicare

Phone: 800-361-4542 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:**

☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Oxandrolone-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Bone pain associated with osteoporosis
☐ Protein catabolism associated with chronic corticosteroid administration
☐ Adjunctive therapy to promote weight gain
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. FOR ADJUNCTIVE THERAPY TO PROMOTE WEIGHT GAIN: Is the requested medication being used after weight loss associated with one of the following?

☐ Extensive surgery
☐ Chronic infections
☐ Severe trauma
☐ Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Oxandrolone-1 Medicare

Phone: 800-361-4542 **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:**

Q6. Does the patient have any of the following (please select all that apply)?

- ☐ Known or suspected carcinoma of the prostate or breast in males
- ☐ Carcinoma of the breast in females with hypercalcemia
- ☐ Pregnancy
- ☐ Nephrosis or nephrotic phase of nephritis
- ☐ Hypercalcemia
- ☐ None of the above

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Pegylated Interferon-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic hepatitis B infection
☐ Chronic hepatitis C
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication prescribed by, or in consultation with, any of the following (please select all that apply)?

☐ Gastroenterologist
☐ Hepatologist
☐ Infectious disease specialist
☐ None of the above

Q6. Does the patient have any of the following (please select all that apply)?

☐ Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Pegylated Interferon-1 Medicare

Phone: 800-361-4542 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:**

☐ Uncontrolled depression
☐ None of the above

Q7. For HEPATITIS C: Please provide the patient's genotype below:

Q8. For HEPATITIS C: Please provide the patient's initial HCV RNA level and, if continuing therapy, the current HCV RNA level and week of treatment:

Q9. For HEPATITIS C: Will the requested medication be used in conjunction with Sovaldi?

☐ Yes ☐ No

Q10. For HEPATITIS C: Is the patient treatment-naive or experienced?

☐ Treatment naive (i.e., has never been treated for hepatitis C) ☐ Treatment experienced (i.e., has received treatment for hepatitis C in the past)

Q11. For HEPATITIS C: Please indicate all treatments the patient has previously tried and the outcome of treatment (i.e., non-responder, relapser, etc.):

Q12. For HEPATITIS C: Please indicate all medications that will be part of the treatment regimen:

Q13. For HEPATITIS C: Please indicate the anticipated duration of therapy for this patient:

Q14. For HEPATITIS C: Does the patient have cirrhosis?

☐ Yes ☐ No

Q15. Does the patient have compensated liver disease?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pemazyre-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cholangiocarcinoma, unresectable locally advanced or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have confirmed fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by a FDA-approved test?

☐ Yes ☐ No

Q6. Has the patient been previously treated?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pemazyre-1 Medicare

Phone: 800-361-4542 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:**

Q8. Is the requested medication prescribed by or in consultation with an oncologist, gastroenterologist, or hepatologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Piqray-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer, advanced or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative?

☐ Yes ☐ No

Q6. Is the patient's cancer PIK3CA-mutated?

☐ Yes ☐ No

Q7. Please select all that apply to this patient:

☐ The patient is male or postmenopausal
☐ The requested medication will be used in combination with fulvestrant
☐ The patient's disease has progressed on or after an endocrine-based regimen

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Piqray-1 Medicare

Phone: 800-361-4542 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:**

☐ None of the above

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pomalyst-1 Medicare

Phone: 800-361-4542 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 the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Multiple myeloma
☐ Kaposi's sarcoma, AIDS-related
☐ Kaposi's sarcoma in a HIV-negative adult
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below.

Q5. FOR AIDS-RELATED KAPOSI'S SARCOMA, has the patient failed highly active antiretroviral therapy (HAART)?

☐ Yes ☐ No

Q6. FOR MULTIPLE MYELOMA, please select all that apply to this patient:

☐ The requested medication will be used in combination with dexamethasone in an adult patient
☐ The patient has received at least 2 prior therapies (including lenalidomide and a proteasome inhibitor)
☐ The patient has demonstrated disease progression on or within 60 days of completion of the last therapy
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pomalyst-1 Medicare

Phone: 800-361-4542 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:**

Q7. Is the patient pregnant?

- ☐ Yes
- ☐ No
- ☐ Not applicable - the patient is not of child-bearing potential

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Promacta-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic idiopathic thrombocytopenic purpura (ITP)
☐ Chronic hepatitis C infection associated thrombocytopenia
☐ Severe aplastic anemia
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For APLASTIC ANEMIA, please select any of the following that apply to the patient:

☐ The patient had an insufficient response to immunosuppressive therapy
☐ The requested medication will be used in combination with standard immunosuppressive therapy
☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Promacta-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pulmonary Fibrosis-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate which medication this request is for:

☐ Esbriet ☐ Ofev

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Chronic fibrosing interstitial lung disease with a progressive phenotype
☐ Idiopathic pulmonary fibrosis (IPF)
☐ Systemic sclerosis-associated interstitial lung disease (ILD)
☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Is the requested medication prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

_____ _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Pulmonary Fibrosis-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Qinlock-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Gastrointestinal stromal tumor (GIST), advanced ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient received prior treatment with 3 or more kinase inhibitors, including imatinib (Gleevec)?

☐ Yes ☐ No

Q6. If the patient has NOT tried 3 or more kinase inhibitors, including imatinib (Gleevec), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Qinlock-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Regranex-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication below:
☐ Lower extremity diabetic neuropathic ulcer ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the ulcer extend into the subcutaneous tissue or beyond and have an adequate blood supply?
☐ Yes ☐ No

Q6. Is the patient 16 years of age or older?
☐ Yes ☐ No

Q7. Does the patient have a known neoplasm at the site of application?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Regranex-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Repatha-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Primary hyperlipidemia (hypercholesterolemia) including heterozygous familial hypercholesterolemia (HeFH)
☐ Homozygous familial hypercholesterolemia
☐ Required prophylaxis of myocardial infarction, stroke, or coronary revascularization in a patient with established cardiovascular disease
☐ Clinical atherosclerotic cardiovascular disease (CVD)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. FOR CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, has the patient experienced any of the following (please select all that apply)?

☐ Acute coronary syndrome
☐ History of myocardial infarction
☐ Stable or unstable angina
☐ Coronary or other arterial revascularization

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Repatha-1 Medicare

Phone: 800-361-4542 **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:**

- ☐ Stroke
- ☐ Transient ischemic stroke (TIA)
- ☐ Peripheral arterial disease (PAD) presumed to be atherosclerotic region
- ☐ None of the above

Q6. Is the patient 13 years of age or older?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Retevmo-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Medullary thyroid cancer (MTC), advanced or metastatic, RET-mutant
☐ Non-small cell lung cancer (NSCLC), metastatic, RET fusion-positive
☐ Thyroid cancer, advanced or metastatic, RET fusion-positive
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient requires systemic therapy (such as the requested medication)
☐ The patient is refractory to radioactive iodine, if appropriate
☐ None of the above

Q6. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Retevmo-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revlimid-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

- ☐ Multiple myeloma
- ☐ Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndrome (MDS)
- ☐ Mantle cell lymphoma
- ☐ Follicular lymphoma
- ☐ Marginal zone lymphoma
- ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For MULTIPLE MYELOMA, please indicate how the requested medication will be used in this patient:

- ☐ In combination with dexamethasone
- ☐ Following autologous hematopoietic stem cell transplantation
- ☐ None of the above

Q6. For TRANSFUSION-DEPENDENT ANEMIA DUE TO MDS, is the condition associated with a deletion 5q

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revlimid-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

cytogenetic abnormality with or without additional cytogenetic abnormalities?

☐ Yes ☐ No

Q7. For MANTLE CELL LYMPHOMA, has the patient relapsed or progressed after two (2) prior therapies (one of which included bortezomib)?

☐ Yes ☐ No

Q8. For FOLLICULAR LYMPHOMA OR MARGINAL ZONE LYMPHOMA, will the requested medication be used in combination with rituximab?

☐ Yes ☐ No

Q9. Is the patient pregnant?

☐ Yes
☐ No
☐ Not applicable - the patient is not of child-bearing potential

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rozlytrek-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ ROS1-positive metastatic non-small cell lung cancer (NSCLC)
☐ Solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below.

Q5. For SOLID TUMORS, please select all that apply to this patient:

☐ The patient's tumors are metastatic or where surgical resection is likely to result in severe morbidity
☐ The patient's tumors have either progressed following treatment or have no satisfactory alternative therapy
☐ None of the above

Q6. Is the patient 12 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Rozlytrek-1 Medicare

Phone: 800-361-4542 **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:**

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rubraca-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer
☐ Epithelial ovarian, fallopian tube, or primary peritoneal cancer
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, please select all that apply to the patient:

☐ The patient has deleterious BRCA mutation (germline and/or somatic) as detected by a FDA-approved test
☐ The patient has been treated with two or more prior lines of chemotherapy
☐ The disease is recurrent
☐ The requested medication will be used as maintenance treatment
☐ The patient is in complete or partial response to platinum-based chemotherapy
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rubraca-1 Medicare

Phone: 800-361-4542 **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:**

Q6. For PROSTATE CANCER, has the patient been treated with androgen receptor-directed therapy and a taxane-based chemotherapy?

☐ Yes ☐ No

Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rydapt-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myelogenous leukemia (AML)
☐ Mast cell leukemia
☐ Systemic mastocytosis
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For ACUTE MYELOGENOUS LEUKEMIA, please select all that apply to the patient:

☐ The patient is treatment naive
☐ The patient is FLT3 mutation-positive
☐ The requested medication will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation therapy
☐ None of the above

Q6. Is the patient 18 years of age or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rydapt-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Is the requested medication being prescribed by or in consultation with an oncologist or hematologist?	
☐ Yes	☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Samsca-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Clinically significant hypervolemic or euvolemic hyponatremia, including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's serum sodium less than 125 mEq/L or less with marked hyponatremia that is symptomatic and has resisted correction with fluid restriction?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Does the patient have any of the following (please select all that apply)?

☐ Anuria

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Samsca-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

- ☐ Concomitant use of strong CYP3A inhibitors (e.g. clarithromycin, ketoconazole, ritonavir)
- ☐ Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)
- ☐ Hypovolemic hyponatremia
- ☐ Inability to sense or appropriately respond to thirst
- ☐ Urgent need to raise serum sodium acutely
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Signifor-1 Medicare

Phone: 800-361-4542 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 the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Cushing's disease ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient had an inadequate response to or is not a candidate for surgery?

☐ Yes ☐ No

Q6. FOR RENEWAL: Is there documentation of a clinically meaningful reduction in 24-hour urinary free cortisol (UFC) levels or improvement in signs or symptoms of the disease?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Signifor-1 Medicare

Phone: 800-361-4542 **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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sildenafil-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (WHO Group I) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Was the patient's diagnosis confirmed by right heart catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?

☐ Yes ☐ No

Q8. Is the patient currently receiving nitrate therapy (includes intermittent use)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sildenafil-1 Medicare

Phone: 800-361-4542 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:**

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somatuline Depot-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acromegaly
☐ Carcinoid syndrome
☐ Gastroenteropancreatic neuroendocrine tumors (GEP-NETs), Unresectable, well or moderately differentiated, locally advanced or metastatic
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For ACROMEGALY, please select any of the following that applies to the patient:

☐ Patient has had an inadequate response to surgery and/or radiotherapy
☐ Patient is not a candidate for surgery and/or radiotherapy
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somatuline Depot-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somavert-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Acromegaly ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient had an inadequate response to or is ineligible for surgery or radiation therapy?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Was the requested medication prescribed by or in consultation with an endocrinologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somavert-1 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sprycel-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL)
☐ Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below.

Q5. For ACUTE LYMPHOBLASTIC LEUKEMIA, please select any of the following that apply to the patient:

☐ Patient had resistance or intolerance to prior therapy
☐ Disease is newly diagnosed and the requested medication will be used in combination with chemotherapy
☐ None of the above

Q6. For CHRONIC MYELOGENOUS LEUKEMIA, please select any of the following that apply to the patient:

☐ Disease is newly diagnosed in the chronic phase
☐ Disease is chronic, accelerated, or myeloid or lymphoid blast phase with resistance or intolerance to prior therapy
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sprycel-1 Medicare

Phone: 800-361-4542 **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:**

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stelara-3 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Crohn's disease, moderate to severely active
☐ Plaque psoriasis, moderate to severe
☐ Psoriatic arthritis, active
☐ Ulcerative colitis, moderate to severely active
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient had a trial and failure or intolerance or contraindication to any of the following (please select all that apply)?

☐ Enbrel ☐ Humira ☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stelara-3 Medicare

Phone: 800-361-4542 **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:**

Q7. Has the patient been screened for latent tuberculosis infection prior to initiation of treatment?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Colorectal cancer, metastatic
☐ Gastrointestinal stromal tumor (GIST), locally advanced, unresectable or metastatic
☐ Liver carcinoma
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For COLORECTAL CANCER, is the patient RAS wild type ?

☐ Yes ☐ No

Q6. For COLORECTAL CANCER, has the patient been previously treated with any of the following (please select all that apply)?

☐ Fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy
☐ Anti-VEGF therapy
☐ Anti-EGFR therapy

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-1 Medicare

Phone: 800-361-4542 **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:**

☐ None of the above

Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. For GASTROINTESTINAL STROMAL TUMORS, has the patient been previously treated with any of the following (please select all that apply)?

☐ Imatinib (Gleevec) ☐ Sunitinib (Sutent) ☐ None of the above

Q9. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q10. For LIVER CARCINOMA, has the patient been previously treated with sorafenib (Nexavar)?

☐ Yes ☐ No

Q11. If the patient has NOT tried sorafenib (Nexavar), is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q12. Is the patient 18 years of age or older?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sunosi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Narcolepsy
☐ Obstructive sleep apnea (OSA)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have excessive daytime drowsiness?

☐ Yes ☐ No

Q6. Does the patient have a trial of or contraindication to any of the following? (Please select all that apply.)

☐ Armodafinil ☐ Modafinil ☐ None of the above

Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sunosi-1 Medicare

Phone: 800-361-4542 **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:**

Q8. Is the patient 18 years old or older?

☐ Yes ☐ No

Q9. Does the patient have any of the following? (Please select all that apply.)

- ☐ Concomitant use of a monoamine oxidase inhibitor (MAOI)
- ☐ Use within 14 days of discontinuing a monoamine oxidase inhibitor (MAOI)
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sutent-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Gastrointestinal stromal tumor
☐ Pancreatic neuroendocrine tumors, unresectable locally advanced or metastatic
☐ Renal cell carcinoma
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For GASTROINTESTINAL STROMAL TUMOR, has the patient had disease progression on or an intolerance to imatinib (Gleevec)?

☐ Yes ☐ No

Q6. If the patient has NOT tried imatinib (Gleevec), is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. For RENAL CELL CARCINOMA, please select all that apply to the patient:

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sutent-1 Medicare

Phone: 800-361-4542 **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:**

☐ The disease is advanced

☐ The requested medication will be used as adjuvant therapy following nephrectomy in a patient who is at high risk for recurrence

☐ None of the above

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symdeko-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystic fibrosis (CF) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select if any of the following apply to this patient:

☐ The patient is homozygous for the F508del mutation

☐ Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-cleared CF mutation test

☐ None of the above

Q6. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by or in consultation with a pulmonologist or a prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symdeko-1 Medicare

Phone: 800-361-4542 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:**

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symlin-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Diabetes mellitus (type 1 or type 2) ☐ Other

Q4. If the patient's diagnosis is OTHER please specify below:

Q5. Does the patient use mealtime insulin therapy and has failed to achieve desired glucose control?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Does the patient have any of the following (please select all that apply)?

☐ Confirmed diagnosis of gastroparesis
☐ Hypoglycemia unawareness
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symlin-2 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tabrecta-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have tumors with a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by a FDA-approved test?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tabrecta-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tafinlar-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Anaplastic thyroid carcinoma, locally advanced or metastatic
☐ Malignant melanoma, unresectable or metastatic
☐ Non-small cell lung cancer, metastatic
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For ANAPLASTIC THYROID CARCINOMA, please select all that apply to the patient:

☐ Patient has BRAF V600E mutation
☐ The requested medication will be used in combination with trametinib (Mekinist)
☐ Patient has no satisfactory locoregional treatment options
☐ None of the above

Q6. For NON-SMALL CELL LUNG CANCER, please select all that apply to the patient:

☐ Patient has BRAF V600E mutation

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tafinlar-1 Medicare

Phone: 800-361-4542 **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:**

☐ The requested medication will be used in combination with trametinib (Mekinist)
☐ Patient was previously treated as monotherapy
☐ None of the above

Q7. For MELANOMA, does the patient have a BRAF V600E or V600K mutation?

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tagrisso-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient has EGFR exon 19 deletion or exon 21 L858R mutation
☐ The requested medication is being used as first-line therapy
☐ There is confirmed presence of T790M EGFR mutation
☐ The patient's disease has progressed on or after EGFR tyrosine kinase inhibitor therapy
☐ The patient's diagnosis was confirmed by a FDA-approved test
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tagrisso-1 Medicare

Phone: 800-361-4542 **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:**

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Takhzyro-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Hereditary angioedema (HAE) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Will the requested medication be used in the prevention of angioedema attacks?
☐ Yes ☐ No

Q6. Does the patient have a trial of or contraindication to Firazyr?
☐ Yes ☐ No

Q7. If the patient has NOT tried Firazyr, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Is the patient 12 years of age or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Takhzyro-1 Medicare

Phone: 800-361-4542 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:**

☐ Yes	☐ No
Q9. Is the requested medication being prescribed by or in consultation with a hematologist, immunologist, or allergist?	
☐ Yes	☐ No

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Talzenna-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer, locally advanced or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have a deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm)?

☐ Yes ☐ No

Q6. Is the patient's disease human epidermal growth factor receptor 2 (HER2)-negative?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with an oncologist?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Talzenna-1 Medicare

Phone: 800-361-4542 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:**

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Targretin Gel-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please indicate the start date (MM/YY):

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

☐ Primary cutaneous T-cell lymphoma (CTCL Stage 1A/1B) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient had an inadequate response, intolerance, or contraindication to at least one prior systemic therapy (e.g., corticosteroids) indicated for cutaneous manifestations of CTCL?

☐ Yes ☐ No

Q6. If the patient has NOT tried one prior systemic therapy (e.g. corticosteroids), is there a reason why it cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Is the requested medication being prescribed by or in consultation with an oncologist or dermatologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Targretin Gel-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tasigna-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in chronic phase
☐ Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in accelerated phase
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select any of the following that applies to the patient:

☐ The patient is newly diagnosed
☐ The patient is resistant or intolerant to prior therapy that included imatinib
☐ The patient is resistant or intolerant to prior tyrosine kinase inhibitor therapy
☐ None of the above

Q6. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tasigna-1 Medicare

Phone: 800-361-4542 **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:**

Q7. Does the patient have any of the following (please select all that apply)?

- ☐ Long QT syndrome
- ☐ Uncorrected hypokalemia
- ☐ Uncorrected hypomagnesemia
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tazverik-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Epithelioid sarcoma, metastatic or locally advanced
☐ Follicular lymphoma, relapsed or refractory
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For EPITHELIOID SARCOMA, is the patient eligible for complete resection?

☐ Yes ☐ No

Q6. For FOLLICULAR LYMPHOMA, please select all that apply to the patient:

☐ The patient has tumors that are positive for an EZH2 mutation as detected by a FDA-approved test
☐ The patient has received at least 2 prior systemic therapies
☐ The patient has no satisfactory alternative treatment options
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tazverik-1 Medicare

Phone: 800-361-4542 **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:**

Q7. Is the patient 16 years of age or older?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tegsedi-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Polyneuropathy of hereditary transthyretin-mediated amyloidosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Does the patient have any of the following (please select all that apply)?

☐ Platelet count less than 100,000 per microliter
☐ Urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher
☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tegsedi-2 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tepmetko-1 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have mesenchymal-epithelial transition (MET) exon 14 skipping alterations?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by or in consultation with an oncologist?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tepmetko-1 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:**

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Teriparatide-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Osteoporosis due to associated sustained systemic glucocorticoid therapy
☐ Postmenopausal osteoporosis
☐ Primary or hypogonadal osteoporosis in a male patient
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have a previous trial and failure, contraindication, or intolerance to a bisphosphonate?

☐ Yes ☐ No

Q6. For POSTMENOPAUSAL OSTEOPOROSIS, does the patient have a history of or contraindication to Tymlos?

☐ Yes ☐ No

Q7. If the patient has NOT tried any of the medication(s) listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Teriparatide-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

Q8. Does the patient have a high risk for fracture?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Has the patient received more than 24 months of treatment with the requested medication?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tetrabenazine-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chorea associated with Huntington's disease ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have any of the following (please select all that apply)?

- ☐ Actively suicidal
- ☐ Untreated or inadequately treated depression
- ☐ Impaired hepatic function
- ☐ Concomitant use of monoamine oxidase inhibitors
- ☐ Concomitant use of reserpine or within 20 days of discontinuing reserpine
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tetrabenazine-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Thalomid-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Multiple myeloma, newly diagnosed
☐ Erythema nodosum leprosum (ENL)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication being prescribed by or in consultation with an oncologist or infectious disease specialist?

☐ Yes ☐ No

Q6. Is the patient pregnant?

☐ Yes
☐ No
☐ Not applicable - patient is not of child-bearing potential

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Thalomid-2 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tibsovo-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The disease is relapsed or refractory
☐ The patient is newly diagnosed
☐ The patient has a susceptible isocitrate dehydrogenase-1 mutation as detected by an FDA-approved test
☐ The patient is 75 years of age or older
☐ The patient has comorbidities that preclude use of intensive induction chemotherapy
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tibsovo-1 Medicare

Phone: 800-361-4542 **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:**

Q7. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trientine-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Wilson's disease ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have an intolerance to penicillamine?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trikafta-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystic fibrosis (CF) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene verified by an FDA-cleared CF mutation test?

☐ Yes ☐ No

Q6. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or a prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trikafta-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tukysa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer, advanced unresectable or metastatic (including brain metastases) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient has HER2-positive breast cancer
☐ The patient has received one or more prior anti-HER2-based regimens in the metastatic setting
☐ The requested medication is being used in combination with trastuzumab (Herceptin) and capecitabine (Xeloda)
☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tukysa-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Turalio-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Tenosynovial giant cell tumor (TGCT) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select if any of the following apply to this patient:

☐ The patient is symptomatic

☐ The patient's disease is associated with severe morbidity or functional limitations and not amenable to improvement with surgery

☐ None of the above

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Turalio-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tymlos-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Postmenopausal osteoporosis ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient had an osteoporotic fracture or has multiple risk factors for fracture?

☐ Yes ☐ No

Q6. Has the patient had a previous trial of or contraindication to a bisphosphonate?

☐ Yes ☐ No

Q7. If the patient has NOT tried a bisphosphonate, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Is the patient 18 years of age or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tymlos-1 Medicare

Phone: 800-361-4542 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:**

☐ Yes	☐ No
Q9. Has treatment duration with the requested medication exceeded 24 months in the patient's lifetime?	
☐ Yes	☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ukoniq-1 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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Marginal zone lymphoma (MZL), relapsed or refractory
☐ Follicular lymphoma (FL), relapsed or refractory
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For MARGINAL ZONE LYMPHOMA, has the patient received at least one prior anti-CD20-based regimen?

☐ Yes ☐ No

Q6. If the patient has NOT tried at least one prior anti-CD20-based regimen, is there a reason why it cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ukoniq-1 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:**

Q7. For FOLLICULAR LYMPHOMA, has the patient received at least three prior lines of systemic therapy?

☐ Yes ☐ No

Q8. If the patient has NOT tried at least three prior lines of systemic therapy, is there a reason why it cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Uptravi-3 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH), WHO Group I ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient's diagnosis been confirmed by right heart catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?

☐ Yes ☐ No

Q8. Is the patient receiving the requested medication concomitantly with strong CYP2C8 inhibitors (e.g.,

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Uptravi-3 Medicare

Phone: 800-361-4542 **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:**

gemfibrozil)?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Venclexta-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic lymphocytic leukemia (CLL)
☐ Small lymphocytic lymphoma (SLL)
☐ Acute myeloid leukemia (AML)
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For ACUTE MYELOID LEUKEMIA, please select all that apply to this patient:

☐ The patient's disease is newly-diagnosed
☐ The requested medication will be used in combination with azacitidine, decitabine or low-dose cytarabine
☐ The patient is 75 years of age or older
☐ The patient has comorbidities that preclude the use of intensive induction chemotherapy
☐ None of the above

Q6. Is the patient 18 years of age or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Venclexta-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes	☐ No
Q7. Is the requested medication prescribed by or in consultation with an oncologist?	
☐ Yes	☐ No
Q8. For CHRONIC LYMPHOCYTIC LEUKEMIA OR SMALL LYMPHOCYTIC LYMPHOMA, will the patient use a strong CYP3A inhibitor concomitantly during the initial and titration phase?	
☐ Yes	☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verquvo-3 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. For CONTINUING THERAPY, please indicate the start date (MM/YY):

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

☐ Chronic heart failure (HF), NYHA Class II to IV ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have a left ventricular ejection fraction less than 45%?

☐ Yes ☐ No

Q6. Has the patient had a previous hospitalization for heart failure (HF) within 6 months or outpatient IV diuretic treatment for HF within 3 months?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verquvo-3 Medicare

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q8. Is the requested medication prescribed by or in consultation with a cardiologist?	
☐ Yes	☐ No
Q9. Is the patient using the requested medication concomitantly with other soluble guanylate cyclase (sGC) stimulators?	
☐ Yes	☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verzenio-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer, advanced or metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to the patient:

☐ The patient's disease is hormone receptor (HR)-positive
☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative
☐ The requested medication is being used in combination with fulvestrant for the treatment of disease progression following endocrine therapy
☐ The requested medication is being used as monotherapy for the treatment of disease progression following endocrine therapy
☐ The requested medication is being used as initial endocrine-based treatment in combination with an aromatase inhibitor
☐ The patient has received at least one prior chemotherapy regimen of Ibrance or Kisqali
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verzenio-1 Medicare

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Patient Name:	**Prescriber Name:**

Q6. What is the patient's menopause status?

- ☐ Postmenopausal
- ☐ Premenopausal or perimenopausal
- ☐ None of the above

Q7. Does the patient have trial and failure or contraindication to any of the following (please select all that apply)?

☐ Ibrance ☐ Kisqali ☐ None of the above

Q8. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Is the requested medication being prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vitrakvi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Solid tumors ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please select all that apply to this patient:

☐ The patient's disease is metastatic or surgically unresectable
☐ The patient's disease is neurotrophic receptor tyrosine kinase (NTRK) gene fusion-positive
☐ The patient has unsatisfactory alternative treatments or has progressed following treatment
☐ None of the above

Q6. Is the requested medication being prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

_____ _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vitrakvi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**
Prescriber Signature	Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vizimpro-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer, metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have confirmed epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by a FDA-approved test?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vizimpro-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Voriconazole-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Invasive aspergillosis
☐ Candidemia
☐ Esophageal candidiasis
☐ Invasive candidiasis of the skin and infections in abdomen, kidney, bladder wall, and wounds
☐ Serious fungal infections due to Scedosporium apiospermum or Fusarium species
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please indicate the route of administration:

☐ Oral ☐ IV

Q6. Is the requested medication prescribed by or in consultation with an infectious disease specialist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Voriconazole-2 Medicare

Phone: 800-361-4542 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:**

Q7. Does the patient reside in a long term care (LTC) or hospital setting? (NOTE: B vs D questions only apply to the IV dose forms)

☐ Yes ☐ No

Q8. Is the medication being given via an infusion pump? (NOTE: B vs D questions only apply to the IV dose forms)

☐ Yes ☐ No

Q9. Did Medicare pay for the infusion pump? (NOTE: B vs D questions only apply to the IV dose forms)

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Votrient-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. What is the patient's diagnosis for the requested medication?

☐ Renal cell carcinoma, advanced
☐ Soft tissue sarcoma, advanced
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. For SOFT TISSUE SARCOMA, has the patient received at least one prior chemotherapy?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by or in consultation with an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Votrient-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vyndamax-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Transthyretin related familial amyloid cardiomyopathy (wild type or hereditary) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with a cardiologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vyndamax-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xalkori-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive or ROS1-positive as detected by a FDA-approved test?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by, or in consultation with, an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xalkori-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xeljanz-4 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Psoriatic arthritis, active
☐ Rheumatoid arthritis, moderate to severe
☐ Ulcerative colitis, moderate to severe
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Has the patient had failure, contraindication, or intolerance to any of the following? (please select all that apply):

☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Q7. Will the patient be screened for latent tuberculosis infection prior to initiation of treatment?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xeljanz-4 Medicare

Phone: 800-361-4542 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:**

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xgeva-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Bone metastases from a solid tumor
☐ Giant cell tumor of the bone
☐ Hypercalcemia of malignancy
☐ Multiple myeloma
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For GIANT CELL TUMOR OF THE BONE, is the patient's disease unresectable or surgical resection is likely to result in severe morbidity?

☐ Yes ☐ No

Q6. For HYPERCALCEMIA OF MALIGNANCY, is the patient's disease refractory to bisphosphonate therapy?

☐ Yes
☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xgeva-2 Medicare

Phone: 800-361-4542 **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:**

☐ Not applicable - the patient has not tried bisphosphonates

Q7. If the patient has NOT tried bisphosphonate therapy, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Is the medication to be used for the prevention of skeletal-related events?

☐ Yes ☐ No ☐ N/A

Q9. Does the patient have hypocalcemia (calcium less than 8.0 mg/dL)?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xolair-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic idiopathic urticaria
☐ Moderate to severe persistent asthma
☐ Nasal polyps
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below.

Q5. For URTICARIA, does the patient remain symptomatic despite H1 antihistamine therapy?

☐ Yes
☐ No
☐ Not applicable - the patient has not tried H1 antihistamine therapy

Q6. If the patient has NOT tried H1 antihistamine therapy, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xolair-2 Medicare

Phone: 800-361-4542 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:**

Q7. For ASTHMA, please select all that apply to the patient:

- ☐ The patient has a positive skin test or in vitro reactivity to a perennial aeroallergen
- ☐ The patient's symptoms are inadequately controlled with inhaled corticosteroids
- ☐ None of the above

Q8. FOR NASAL POLYPS, has the patient had an inadequate response to nasal corticosteroids?

☐ Yes ☐ No

Q9. If the patient has NOT tried nasal corticosteroids, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q10. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q11. Is the requested medication prescribed by or in consultation with an allergist, dermatologist, immunologist, otolaryngologist, or pulmonologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xospata-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia, relapsed or refractory ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the patient have a presence of an FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xospata-2 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xpovio-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Diffuse large B-cell lymphoma, relapsed or refractory (DLBCL, including from follicular lymphoma)
☐ Multiple myeloma, relapsed or refractory
☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. For DIFFUSE LARGE B-CELL LYMPHOMA, has the patient received at least 2 lines of systemic therapy?

☐ Yes ☐ No

Q6. For MULTIPLE MYELOMA, will the requested medication be used in combination with dexamethasone?

☐ Yes ☐ No

Q7. For MULTIPLE MYELOMA, has the patient received at least 4 prior therapies?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xpovio-1 Medicare

Phone: 800-361-4542 **Fax back to: 877-503-7231**

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Patient Name:	**Prescriber Name:**

Q8. For MULTIPLE MYELOMA, is the patient's disease refractory to any of the following? (Please select all that apply)

- ☐ At least two proteasome inhibitors
- ☐ At least two immunomodulatory agents
- ☐ An anti-CD38 monoclonal antibody
- ☐ None of the above

Q9. If the patient has NOT tried any of the medications listed in the previous question(s), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q10. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q11. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Prostate cancer (castration-resistant)
☐ Prostate cancer (metastatic, castration-sensitive)
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by (or in consultation with) an oncologist or urologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-1 Medicare

Phone: 800-361-4542 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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xuriden-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hereditary orotic aciduria ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Narcolepsy with cataplexy
☐ Narcolepsy with excessive daytime drowsiness
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. FOR NARCOLEPSY WITH EXCESSIVE DAYTIME DROWSINESS: Does the patient have a trial of or contraindication to any of the following? (Please select all that apply)

☐ Modafinil ☐ Armodafinil ☐ None of the above

Q6. If the patient has NOT tried modafinil or armodafinil, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Is the patient 7 years of age or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes ☐ No

Q8. Does the patient have any of the following? (Please select all that apply)

- ☐ Concomitant treatment with sedative hypnotic agents
- ☐ Succinic semialdehyde dehydrogenase deficiency
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xywav-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Narcolepsy with cataplexy
☐ Narcolepsy with excessive daytime drowsiness
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. FOR NARCOLEPSY WITH EXCESSIVE DAYTIME DROWSINESS: Does the patient have a trial of or contraindication to any of the following? (Please select all that apply)

☐ Modafinil ☐ Armodafinil ☐ None of the above

Q6. If the patient has NOT tried modafinil or armodafinil, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q7. Is the patient 7 years of age or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xywav-1 Medicare

Phone: 800-361-4542 **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:**

☐ Yes	☐ No

Q8. Does the patient have any of the following? (Please select all that apply)

- ☐ Concomitant treatment with sedative hypnotic agents
- ☐ Succinic semialdehyde dehydrogenase deficiency
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Yonsa-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication below:
☐ Prostate cancer (metastatic, castration-resistant) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the requested medication being used in combination with methylprednisolone?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?
☐ Yes ☐ No

Q8. Is the patient's partner pregnant?
☐ Yes ☐ No ☐ Not Applicable

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Yonsa-1 Medicare

Phone: 800-361-4542 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:**

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zarxio-1 Medicare

Phone: 800-361-4542 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 the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis
☐ Chemotherapy-induced febrile neutropenia, prophylaxis
☐ Hematopoietic subsyndrome of acute radiation syndrome (H-ARS)
☐ Severe chronic neutropenia
☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

_____ _____

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Advanced or recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer

☐ Advanced ovarian, fallopian tube, or primary peritoneal cancer

☐ Other

Q4. For ADVANCED OR RECURRENT EPITHELIAL OVARIAN CANCER, RECURRENT FALLOPIAN TUBE CANCER, OR RECURRENT PRIMARY PERITONEAL CANCER, please select all that apply to this patient:

☐ The requested medication will be used as maintenance therapy

☐ The patient is in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin)

☐ None of the above

Q5. For ADVANCED OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, please select all that apply to this patient:

☐ The patient has been treated with 3 or more prior chemotherapy regimens

☐ The patient's cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA mutation, or genomic instability

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-2 Medicare

Phone: 800-361-4542 **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:**

☐ The patient's disease has progressed more than 6 months after response to the last platinum-based chemotherapy

☐ None of the above

Q6. If the patient's diagnosis is OTHER, please specify below:

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by (or in consultation with) an oncologist or gynecologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ziextenzo-1 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chemotherapy-induced febrile neutropenia (prophylaxis) ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zykadia-2 Medicare

Phone: 800-361-4542 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. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by, or in consultation with, an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zykadia-2 Medicare

Phone: 800-361-4542 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:**
Prescriber Signature	Date