

MEDICAL RX COVERAGE DETERMINATION REQUEST FORM

Patient Name			Prescriber Name		
Member ID #			Prescriber NPI#	Tax ID Number	
Sex (circle)	M	F	DOB	Office Phone	Office Fax
Height	Weight	Allergies		Servicing Provider (if applicable)	
Contact Person			Servicing Provider NPI#	Tax ID Number	
Medication, Strength, & Dose			Route of Admin.	Directions	
<input type="checkbox"/> New Therapy: Date to Start: _____ <input type="checkbox"/> Continuation: Date Began: _____				Expected Length of Therapy	
Diagnosis for Medication Treatment			ICD10 Code	HCPCS Code	
PRESCRIBER'S SIGNATURE (Required) _____				Date	
<p><u>This section must be completed.</u> Incorrect completion may result in delays in reimbursement or provision of service.</p> <p><input type="checkbox"/> The medical benefit ("Buy and Bill") - HCPCS CODE: _____ Total Billable Units: _____</p> <p>Supporting Administration Code(s) - HCPCS CODE: _____</p>					
<p>Rationale for Exception Request or Prior Authorization (Must attach supporting clinical notes)</p> <p><input type="checkbox"/> Alternate covered drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) and completed MedWatch Form. Specify: (1) Covered drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each;</p> <p>_____</p> <p><input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. Specify: (1) Anticipated significant adverse clinical outcome(s) below;</p> <p><input type="checkbox"/> Medical need for different dosage form and/or higher dosage; Specify: (1) New dosage form; (2) Dosage tried; (3) Documented medical reason</p> <p><input type="checkbox"/> Other: _____ (Explain below)</p>					
<p>Required Explanation:</p>					

Disclaimer:

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