



RxAmerica
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Coverage Determination Form

This form cannot be used to request drugs excluded from Medicare Part D, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, cough and cold, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Only one medication request per form ••• All fields must be complete and legible for review

<input type="checkbox"/> Standard Review (72 Hours)		<input type="checkbox"/> Expedited Review (24 Hours)	
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain optimal function.			
Patient Information		Medication Information	
Patient Name:		Medication, Strength and Route of Administration:	
Member ID:		Quantity and Directions:	
Date of Birth:	Patient Phone Number:	Diagnosis/ICD 9:	
Patient Height/Weight/BMI:		Expected Length of Therapy:	New Prescription -OR- Date Therapy Initiated: / /
Physician Name and Specialty:		Drug Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No (Please List)	
Physician DEA or NPI:	Contact Person:	If injectable, is patient self-administering drug? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who will administer drug?	
Office Phone:	Office Fax:	If Transplant Drug: Was the transplant covered by Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date:	
Pharmacy Name, Phone and Fax:		If Oral Anti-emetic: Is the drug being used as a "full replacement" of IV administration within 48 hours of cancer treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rationale For Exception Request or Prior Authorization			
NOTE: FORM CAN NOT BE PROCESSED WITHOUT REQUIRED EXPLANATION			
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg. toxicity, allergy, or therapeutic failure) <input type="checkbox"/> Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy for drug(s); <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 <input type="checkbox"/> Specify below: Anticipated significant adverse clinical outcome <input type="checkbox"/> Medical need for different dosage form &/or higher dosage <input type="checkbox"/> Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason <input type="checkbox"/> Request for formulary tier exception List alternate drug(s) contraindicated or previously tried, but with adverse outcome(s) (e.g. toxicity, allergy, or therapeutic failure): (1) Drug(s) tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); (1) _____ (2) _____ (3) _____ (1) _____ (2) _____ (3) _____ (1) _____ (2) _____ (3) _____			
In order to complete the review process, chart notes documenting trial and failure on the above medication and pertinent laboratory tests and results must be included.			
Prescriber's Signature:			Date:

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