Step Therapy Criteria

PPI

Products Affected

Step 2:

- DEXILANT CAPSULE DELAYED RELEASE 30 MG ORAL
- DEXILANT CAPSULE DELAYED RELEASE 60 MG ORAL

Details

Criteria	Claim will pay automatically for Dexilant if enrollee has a paid claim for at least a 1 days supply of step level 1 agent (lansoprazole, esomeprazole, omeprazole, pantoprazole, or rabeprazole) in the past. Otherwise, Dexilant requires a step therapy exception request indicating: (1) history of inadequate treatment response with step 1 agent, OR (2) history of adverse event with step 1 agent, OR (3) step 1 agent is contraindicated.

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trelegy-15 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 Envision 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 Start Date:

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

☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Other

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

Q5. Does the patient have a history of failure, contraindication, or intolerance to any of the following formulary alternatives?

- ☐ Advair Diskus
- ☐ Anoro Ellipta
- ☐ Breo Ellipta
- ☐ Fluticasone/Salmeterol
- ☐ Serevent Diskus
- ☐ Spiriva HandiHaler
- ☐ Spiriva Respimat
- ☐ None of the above

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Patient Name:	**Prescriber Name:**

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

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Uloric-12 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 Envision 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 Start Date (MM/YY):

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

☐ Gout ☐ Other

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

Q5. Has the patient tried and failed ALLOPURINOL?

☐ Yes ☐ No

Q6. If the patient has NOT tried ALLOPURINOL, please indicate the reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Uloric-12 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**