

EOC ID:

Abiraterone-1 Medicare

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

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 applic	cable):
*Please note that Elixir will process the request as written	en, including drug name, wi	th no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may supp estions and sign.	ort approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Metastatic prostate cancer, castration-resistant		
☐ Metastatic prostate cancer, high-risk, castration-sensit☐ Other	ive	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the requested medication being used in combinatio	n 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 consu	Itation with an oncologist or ur	ologist?
☐ Yes	□ No	



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Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Actimmune-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 reques	t as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or in following	nformation for this patient that ma lowing questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy	у?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please pro	vide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for th	e requested medication:	
☐ Chronic granulomatous disease	·	
Severe malignant osteopetrosis (SMO)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, pleas	e specify below:	
Q5. For CHRONIC GRANULOMATOUS DISEAS severity of serious infections?	SE, will the requested medication	n be used to reduce the frequency and
☐ Yes	□No	
Prescriber Signature		Date

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Patient Name:	Prescriber Name:

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EOC ID:

Adempas-2 Medicare

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

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	f applicable):
*Please note that Elixir will process the req	uest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	тару
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for Chronic thromboembolic pulmonary him Pulmonary arterial hypertension (PAH	ypertension (CTEPH), World Health C	rganization group 4
Q4. If the patient's diagnosis is OTHER, p	lease specify below:	
Q5. For CTEPH, please select all that apply Patient has persistent or recurrent disc Patient's disease is inoperable None of the above		lmonary endarterectomy)
Q6. For PAH, was the diagnosis confirmed to undergo a right heart catheterization (e.g.		er echocardiogram if patient is unable
	□ 140	



EOC ID:

Adempas-2 Medicare

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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 consul	tation with a pulmonologist or cardiologist?
☐ Yes		□ No
Q10. Does the patient have any of the follow	wing (please se	lect all that apply)?
☐ Concomitant administration with nitra	tes or nitric oxi	de donors (such as amyl nitrate) in any form
·	•	inhibitors, including specific PDE-5 inhibitors (such as
	ecific PDE inhib	pitors (such as dipyridamole or theophylline)
☐ Pregnancy		
Pulmonary hypertension associated v	with idiopathic i	nterstitial pneumonia
☐ None of the above		
Prescriber Signature		



FOC ID

Afinitor Disperz-1 Medicare

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

Different No.	B	
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 na	ame, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform		ay support approval. Please answer the
TOIIOWI	ng questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the re	quested medication:	
☐ Tuberous sclerosis complex (TSC)-associated page 1	artial-onset seizures	
☐ Subependymal giant cell astrocytoma (SEGA) as		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please sp	pecify below:	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
Q5. For SEGA ASSOCIATED WITH TSC, is the pati	ent a candidate for curative	surgical resection?
Yes	□No	-
	_	
Q6. Is the requested medication prescribed by, or in	consultation with, an oncolo	gist or neurologist?
☐ Yes	☐ No	
Drocaribar Signatura		Data
Prescriber Signature		Date



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Afinitor Disperz-1 Medicare

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Patient Name:	Prescriber Name:



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Alecensa-1 Medicare

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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 (f applicable):
*Please note that Elixir will process the request as write	ten, including drug nar	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	n for this patient that ma uestions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
	to don Pos Con	
Q3. Please indicate the patient's diagnosis for the reques	ted 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 detecte	ed by a FDA-approved test?
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



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Alecensa-1 Medicare

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Patient Name:	Prescriber Name:

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Alkindi-1 Medicare

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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 ap	plicable):
*Please note that Elixir will process the request as writt	en, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may suestions and sign.	upport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	y
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Adrenocortical insufficiency	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient require dosages not available with o	her available formulations	of hydrocortisone?
☐ Yes	□No	
Q6. If the patient has NOT tried other available formulat medications cannot be used (i.e., contraindication, history		nere a reason why these
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 endocr	inologist or pediatrician?



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Alkindi-1 Medicare

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Patient Name:	Prescriber Name:	
☐ Yes	□ No	
Prescriber Signatur	re Date	



EOC ID:

Alpha-1 Proteinase Inhibitor-1 Medicare

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

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	e (if applicable):
*Please note that Elixir will process the request as writt	en, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that mestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 h	ospital setting?	



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Alpha-1 Proteinase Inhibitor-1 Medicare

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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



EOC ID:

Alunbrig-1 Medicare

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

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 re-	quest as written, including drug nar	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	y or information for this patient that ma following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing th	erapy?	
☐ Initial therapy	☐ Continuing the	rany
Initial therapy		тару
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Anaplastic lymphoma kinase (ALK)-ponon-small cell lung cancer (NSCLC)	ositive metastatic	
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 oncologis	st or hematologist?
☐ Yes	□ No	
Prescriber Signature		Date



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Alunbrig-1 Medicare

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Alyq-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		approval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
O2 For CONTINUING THEPARY places provide the a	tort data (MM/VV):	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MIM/ f f).	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Pulmonary arterial hypertension (PAH)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	helow:	
Q4. If the patient's diagnosis is OTTLIX, please specify	below.	
Q5. Was the patient's diagnosis confirmed by right heart c	atheterization or Doppler echocar	diogram 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 use)?	or guanylate cyclase stimulators (includes intermittent
Yes	□ No	
I		



EOC ID:

Alyq-1 Medicare

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Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Ambrisentan-2 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
_		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Pulmonary arterial hypertension (PAH), World Health Organization group 1	Other	
Q4. If the patient's diagnosis is OTHER, please specify I	pelow:	
Q5. Was the diagnosis confirmed by right heart catheteriza undergo a right heart catheterization (e.g., patient is frail, e		the patient is unable to
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Is the requested medication prescribed by or in consul	tation with a pulmonologist or card	diologist?
☐ Yes	□ No	



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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 v	vith pulmonary hypertension
☐ None of the above	
Prescriber Signature	Date



EOC ID:

Amphetamines-1 Medicare

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Date of Birth: Group Number: Address: City, State ZIP: Primary Phone: *Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent Drug Name and Strength:	Patient Name:	Prescriber Name:	
Group Number: Address: Address: City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Member/Subscriber Number:	Fax:	Phone:
Address: City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. 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	Date of Birth:	Office Contact:	
City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Group Number:	NPI:	State Lic ID:
Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Address:	Address:	
Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	City, State ZIP:	City, State ZIP:	
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	Primary Phone:	Specialty/facility name (if applicable)	:
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	*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
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		☐ Expedited/Urgent	
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	Drug Name and Strength:		
Q1. Is this request for initial or continuing therapy? Initial therapy	Directions / SIG:		
☐ 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?			oproval. Please answer the
☐ 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?			
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:	Q1. Is this request for initial or continuing therapy?		
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:	☐ Initial therapy	☐ Continuing therapy	
 ☐ 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?	Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
 ☐ 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?	Q3. Please indicate which medication is being requested:		
 □ 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?			
 □ 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? 			
□ 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?	·		
☐ 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?	l <u> </u>		
□ 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?	Q4. Please indicate the patient's diagnosis for the requeste	ed medication:	
□ 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?	☐ Attention Deficit Hyperactivity disorder (ADHD)		
Q5. If the patient's diagnosis is OTHER, please specify below: Q6. For NARCOLEPSY, has the diagnosis been confirmed by a sleep study?			
Q6. For NARCOLEPSY, has the diagnosis been confirmed by a sleep study?	☐ Other		
Q6. For NARCOLEPSY, has the diagnosis been confirmed by a sleep study?	Q5. If the patient's diagnosis is OTHER, please specify	below:	
☐ Yes ☐ No	Q6. For NARCOLEPSY, has the diagnosis been confirmed	I by a sleep study?	
	☐ Yes	□ No	



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		



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	le):
*Please note that Elixir will process the request as writte	n, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support stions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the sta	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	d medication:	
☐ Cryopyrin-associated periodic syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS and Muckle-Wells Syndrome (MWS)	S) Other	
Q4. If the patient's diagnosis is OTHER, please specify b	elow:	
Q5. Is the patient 12 years of age or older?		
☐ Yes	□ No	
Prescriber Signature		Date



EOC ID:

Arikayce-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
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 requeste	ed 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 copatient?	ombination antibacterial regimen in	a treatment refractory
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Is the requested medication prescribed by or in consul pulmonologist?	Itation with an infectious disease s	pecialist or
☐ Yes	□ No	



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		



EOC ID:

Auryxia-1 Medicare

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

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 writte	en, 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 star	t date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 consu	Itation with a hematologist or neph	rologist?
☐Yes	□ No	



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:	
Q9. Does the patient have iron overload syndrome (e.g., h	nemochromatosis)?	
☐ Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Austedo-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
2		
Please attach any pertinent medical history or information following que	for this patient that may support a	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Chorea associated with Huntington's disease (Hunting	ton'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 consul	tation with a neurologist or psychi	atrist?
☐ Yes	□ No	
Q7. Does the patient have any of the following (please sele	ect all that apply)?	
☐ Hepatic impairment ☐ Suicidal ideation		



EOC ID:

Austedo-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:
☐ Untreated or inadequately treated depression ☐ None of the above	
Q8. Is the patient taking MAOIs, reserpine, or tetrabenazin	e?
Yes	□ No
Prescriber Signature	



EOC ID:

Ayvakit-1 Medicare

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

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 na	nme, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform	nation for this nationt that m	av sunnart annroval. Plaasa answar the
	ng questions and sign.	ay support approval. Flease answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the rec		
Gastrointestinal stromal tumor, unresectable or metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please sp	ecify below:	
Q5. Is there presence of platelet-derived growth factor D842V mutations?	or receptor alpha (PDGFRA)	exon 18 mutation, including PDGFRA
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
	□ Na	
Yes	☐ No	
Prescriber Signature		



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:
This also are the control of the state in the control of the state of the control of the state of the state of the control of the state of the	



EOC ID:

Balversa-2 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support a	approval. Please answer the
Tollowing que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Urothelial carcinoma, locally advanced or metastatic	Other	
Q4. If the patient's diagnosis is OTHER, please specify I	pelow:	
Q5. Please select all that apply to the patient:		
☐ The patient has susceptible FGFR3 or FGFR2 gene	tic alterations	
☐ The patient has susceptible For No of For N2 gene		aining chemotherapy.
including within 12 months of neoadjuvant or adjuvant plat		anning erromemerapy,
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
Yes	Пмо	
☐ 162	□ No	
Q7. Is the requested medication prescribed by or in consul	tation with an oncologist or urolog	gist?
☐ Yes	□ No	



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		



EOC ID:

Bosentan-2 Medicare

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

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 writ	ten, including drug nam	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following quantum process.	on for this patient that may uestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted 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 (N	NYHA) Functional Class I	I-IV symptoms?
Yes	☐ No	
Q6. Was the diagnosis confirmed by right heart catheteriz undergo a right heart catheterization (e.g., patient is frail,	• •	diogram if patient is unable to
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by or in const	ultation with a pulmonolog	gist or cardiologist?
☐ Yes	☐ No	



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:
Q8. Does the patient have any of the following? (Please se	elect all that apply.)
 ☐ Concomitant use of cyclosporine A or glyburide therapy ☐ Pregnancy ☐ None of the above 	
Prescriber Signature	Date



EOC ID:

Bosulif-1 Medicare

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

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	e (if applicable):
*Please note that Elixir will process the request as writt	en, including drug n	name, with no substitution.
	☐ Expedited/L	Irgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that restions and sign.	may support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	herapy
Q2. If the request is for CONTINUING THERAPY, pleas	se provide the start da	ate (MM/YY):
Q3. Please indicate the patient's diagnosis for the request	ed 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 pt☐ The patient has resistance or an inadequate respon☐ 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?



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	 e	Date



EOC ID:

Braftovi-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support apestions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Colorectal cancer, metastatic		
☐ Melanoma, unresectable or metastatic ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify bel	ow:	
Q5. For COLORECTAL CANCER, please select all that ap	ply 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 ☐ None of the above	on with cetuximab (Erbitux)	
Q6. For MELANOMA, please select all that apply to the pa	tient:	
☐ The patient has documented BRAF V600E or V600♭	K mutation as detected by a FDA-a	approved test
☐ The requested medication will be used in combination	on with binimetinib (Mektovi)	



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:
☐ 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 consul	tation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Brukinsa-1 Medicare

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

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 (it	f applicable):
*Please note that Elixir will process the reque	st as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or	information for this patient that may ollowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therap	py?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please pr	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for t	he requested medication:	
☐ Mantle cell lymphoma (MCL)	☐ Other	
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Has the patient tried one prior therapy?		
☐ Yes	□No	
Q6. If the patient has NOT tried any prior the contraindication, history of adverse event, etc.	•	e medications cannot be used (i.e.,
Q7. Is the patient 18 years of age or older?		
arrio are pariorities years or age or order.		



EOC ID:

Brukinsa-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



EOC ID:

Cablivi-1 Medicare

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

Patient Name:	Prescriber Name	<u>: </u>
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 n	ame (if applicable):
*Please note that Elixir will process the request a	as written, including dru	g name, with no substitution.
	☐ Expedite	ed/Urgent
Drug Name and Strength:		
Dissetions / OIC.		
Directions / SIG:		
Please attach any pertinent medical history or info	ormation for this nationt th	at may support approval. Please answer the
	wing questions and sign.	at may support approval. I lease answer the
Q1. Is this request for initial or continuing therapy?		
Q1. Is this request for initial of continuing therapy:		
☐ Initial therapy		ng therapy
☐ Initial therapy	☐ Continuir	
	☐ Continuir	
☐ Initial therapy Q2. For CONTINUING THERAPY, please provide	☐ Continuir	
☐ Initial therapy Q2. For CONTINUING THERAPY, please provide Q3. Please indicate the patient's diagnosis for the	Continuir de the start date (MM/YY) requested medication:	
☐ Initial therapy Q2. For CONTINUING THERAPY, please provide	Continuir de the start date (MM/YY) requested medication:	
☐ Initial therapy Q2. For CONTINUING THERAPY, please provide Q3. Please indicate the patient's diagnosis for the	☐ Continuir de the start date (MM/YY) requested medication: ura (aTTP) ☐ Other	
☐ Initial therapy Q2. For CONTINUING THERAPY, please provid Q3. Please indicate the patient's diagnosis for the ☐ Acquired thrombotic thrombocytopenic purpu	☐ Continuir de the start date (MM/YY) requested medication: ura (aTTP) ☐ Other	
☐ Initial therapy Q2. For CONTINUING THERAPY, please provid Q3. Please indicate the patient's diagnosis for the ☐ Acquired thrombotic thrombocytopenic purpu	☐ Continuir de the start date (MM/YY) requested medication: ura (aTTP) ☐ Other specify below:	:
☐ Initial therapy Q2. For CONTINUING THERAPY, please provide Q3. Please indicate the patient's diagnosis for the ☐ Acquired thrombotic thrombocytopenic purput Q4. If the patient's diagnosis is OTHER, please Q5. Is the requested medication being used in continuous conti	Continuir de the start date (MM/YY) requested medication: ura (aTTP)	:
☐ Initial therapy Q2. For CONTINUING THERAPY, please provided and a second continuity of the patient's diagnosis for the continuity of the patient's diagnosis is OTHER, please continuity of the patient's diagnosis is OTHER, pleas	☐ Continuir de the start date (MM/YY) requested medication: ura (aTTP) ☐ Other specify below:	:
☐ Initial therapy Q2. For CONTINUING THERAPY, please provide Q3. Please indicate the patient's diagnosis for the ☐ Acquired thrombotic thrombocytopenic purput Q4. If the patient's diagnosis is OTHER, please Q5. Is the requested medication being used in continuous conti	Continuir de the start date (MM/YY) requested medication: ura (aTTP)	
☐ Initial therapy Q2. For CONTINUING THERAPY, please provide Q3. Please indicate the patient's diagnosis for the ☐ Acquired thrombotic thrombocytopenic purpout Q4. If the patient's diagnosis is OTHER, please Q5. Is the requested medication being used in community of the patient of the	Continuir de the start date (MM/YY) requested medication: ura (aTTP)	:
☐ Initial therapy Q2. For CONTINUING THERAPY, please provided and a second continuity of the patient's diagnosis for the continuity of the patient's diagnosis is OTHER, please continuity of the patient's diagnosis is OTHER, pleas	☐ Continuinded the start date (MM/YY) requested medication: ura (aTTP) ☐ Other specify below: ☐ No ☐ No	hange and immunosuppression therapy?



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:
Prescriber Signature	Date



EOC ID:

Cabometyx-1 Medicare

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

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 (it	f applicable):
*Please note that Elixir will process the red	quest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	y or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Oo Blace is Fred all a confer the Fred and a	South a constant of the Parker	
Q3. Please indicate the patient's diagnosis f	or the requested medication:	
Renal cell carcinoma, advanced		
☐ Hepatocellular carcinoma, advanced☐ Other		
U Other		
Q4. If the patient's diagnosis is OTHER, μ	please specify below:	
Q5. For HEPATOCELLULAR CARCINOMA	, has the patient been previously treat	ed with sorafenib (Nexavar)?
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Prescriber Signature		Date



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:



EOC ID:

Calquence-1 Medicare

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

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 wr	itten, including drug na	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informat	ion for this patient that ma questions and sign.	y support approval. Please answer the
	quosiiono ana oigin	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rany
		нару
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
	sica medication.	
Chronic lymphocytic leukemia (CLL)		
☐ Mantle cell lymphoma (MCL) ☐ Small lymphocytic lymphoma (SLL)		
Other		
_		
Q4. If the patient's diagnosis is OTHER, please speci	fy below:	
Q5. For MANTLE CELL LYMPHOMA, has the patient tri	ied at least one other ther	anv?
		ару:
Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by or in con-	sultation with an oncologi	st or hematologist?
☐ Yes	☐ No	



EOC ID:

Calquence-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 Nam	Prescriber Name:	
		·		
	Prescriber Signature		Date	



EOC ID:

Caprelsa-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Medullary thyroid cancer (MTC)	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
	and the contract of the contra	
Q5. Is the patient's disease metastatic or unresectable, loc	•	
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	



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 Nam	e:
		·	
	Prescriber Signature		Date



EOC ID:

Cayston-1 Medicare

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

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 a	pplicable):
*Please note that Elixir will process the	request as written, including drug name	, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical hist	ory or information for this patient that may s following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnos	is for the requested medication:	
☐ Cystic fibrosis	☐ Other	
Q4. If the patient's diagnosis is OTHER	R, please specify below:	
	d b	
	d by appropriate diagnostic or genetic testi	ng?
Yes	□No	
Q6. Does the patient have suspected or o	confirmed Pseudomonas aeruginosa infecti	on?
☐ Yes	□ No	
Q7. Is the patient 7 years of age or older	?	
☐ Yes	□No	



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:
Prescriber Signature	Date



EOC ID:

Cinryze-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 ☐ The requested medication is being used in prevention ☐ None of the above	<u> </u>	aryngeal attacks
Q6. Is the patient 6 years of age or older?		
☐ Yes	□No	
Q7. Is the requested medication prescribed by or in consu	Itation with a hematologist, immur	nologist, or allergist?
☐ Yes	□No	



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



EOC ID:

CNS Stimulants-1 Medicare

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

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 w	ritten, including drug na	ame, with no substitution.
	☐ Expedited/Ui	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	ation for this patient that m g questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	ne start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	uested medication:	
□ Narcolepsy		
☐ Obstructive sleep apnea (OSA)		
☐ Shift work disorder (SWD)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please spe-	cify below:	
Q5. For NARCOLEPSY or OBSTRUCTIVE SLEEP AF evaluation?	NEA, was the patient's di	agnosis confirmed by sleep lab
☐ Yes	□ No	
Prescriber Signature		Date



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:
This telecopy transmission contains confidential information belonging to the sender th	nat is legally privileged. This information is intended only for the use of the individual or
I his telecopy transmission contains confidential information belonging to the sender tr	• • • •



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	p):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may support a	approval. Please answer the
following qu	estions and sign.	approvan r rouge anomer and
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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



EOC ID:

Copiktra-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / Gre.		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic lymphocytic leukemia		
☐ Follicular lymphoma		
☐ Small lymphocytic lymphoma		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Is the patient's disease relapsed or refractory?		
	□Ne	
Yes	□ No	
Q6. Does the patient have a history of at least two prior the	erapies?	
Yes	□ No	
Q7. If the patient has NOT tried two prior therapies, is the event, etc.)?	ere a reason why (i.e., contraindic	ation, history of adverse



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 consul	tation with an oncologist or hematologist?
☐ Yes	□ No
Prescriber Signature	



EOC ID:

Corlanor-1 Medicare

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

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 (i	if applicable):
*Please note that Elixir will process the requ	uest as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing the	rapy?	
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis fo	·	
Stable, symptomatic chronic heart failu		
☐ Stable, symptomatic heart failure due t☐ Other	o dilated cardiomyopathy	
Q4. If the patient's diagnosis is OTHER, pl	ease specify below:	
Q5. For CHRONIC HEART FAILURE, please	select all that apply to the patient:	
The patient has a left ventricular ejection		
The patient has a left verificular ejection. The patient is in sinus rhythm with rest	, ,	more
The patient is on maximally tolerated d	•	more
☐ The patient has a contraindication to be		
None of the above	3.5 3.50.00	
Q6. For HEART FAILURE DUE TO DILATED heart rate?	CARDIOMYOPATHY, is the patient	t in sinus rhythm with an elevated



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 se	elect all that apply.)
☐ Bradycardia (i.e., resting heart rate is less than 60 b	eats per minute prior to treatment)
☐ Decompensated acute heart failure	
☐ Hypotension (i.e., blood pressure less than 90/50 mi	mHg)
☐ 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



EOC ID:

Cosentyx-3 Medicare

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

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 application	able):
*Please note that Elixir will process the request as writte	en, including drug name, wit	h no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may suppo estions and sign.	ort approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the star	t 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 follo	wing? (Please select all that ap	oply.)
☐ Humira ☐ Enbrel	□N	one 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?	



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 Signatur	re Date	



EOC ID:

Cotellic-2 Medicare

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

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	e (if applicable):
*Please note that Elixir will process the request as writt	en, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that mestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
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	on?	
☐ Yes	☐ No	
Q6. Is the requested medication being used in combinatio	n with vemurafenib (Z	elboraf)?
☐ Yes	☐ No	
Prescriber Signature		Date



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:

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EOC ID:

Cystaran-2 Medicare

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

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 requ	est as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history o	r information for this patient that ma following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing there	apy?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please p	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, ple	ase specify below:	
Q5. Does the patient have corneal cystine crys	stal accumulation?	
☐ Yes	☐ No	
Q6. Does the patient have demonstrated hype	ersensitivity to cysteamine or penicil	llamine?
☐Yes	□No	
Prescriber Signature		Date



EOC ID:

Cystaran-2 Medicare

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

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Patient Name:	Prescriber Name:

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EOC ID:

Dalfampridine-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	 Fax:	Phone:
Date of Birth:	Office Contact:	i none.
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 writte	en, including drug name, with n	o 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 request	ed 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 se	elect all that apply.)	



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



EOC ID:

Daurismo-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
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 requeste	ed 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	n 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 consul	Itation with an oncologist or hemat	ologist?
☐ Yes	□ No	



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		



EOC ID:

Deferasirox-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	i for this patient that may support a estions and sign.	pproval. Please answer the
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 requeste	ed medication:	
☐ Chronic iron overload due to blood transfusions (transfusion hemosiderosis)		
☐ Chronic from overload due to blood transitisions (transitision hemosiderosis) ☐ Chronic iron overload in non-transfusion-dependent thalassemia syndromes		
Other		
OA 16th and bell and be CTUED allows and file		
Q4. If the patient's diagnosis is OTHER, please specify	Delow:	
Q5. For CHRONIC IRON OVERLOAD DUE TO BLOOD T	RANSFUSIONS, 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-TRANSFU	SION-DEPENDENT THALASSEN	/IIA SYNDROMES, please
select all that apply to the patient:		71
☐ The patient has liver iron concentrations of at least 5 mg Fe/g dry weight		
☐ The patient has serum ferritin level greater than 300		



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 se	elect 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



EOC ID:

Diacomit-1 Medicare

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

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	e (if applicable):
*Please note that Elixir will process the request as wi	ritten, including drug na	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following	tion for this patient that m questions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
Severe myoclonic epilepsy in infancy (Dravet syndrome)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spec	ify below:	
Q5. Is the patient taking clobazam?		
☐ Yes	☐ No	
Q6. Is the requested medication being prescribed by or	in consultation with a ne	eurologist?
☐ Yes	□No	
Prescriber Signature		Date



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:



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 i	request as written, including drug nam	e, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing then	ару
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s for the requested medication:	
☐ Actinic keratosis	☐ Other	
Q4. If the patient's diagnosis is OTHER	R, please specify below:	
Prescriber Signature		Date



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 writte	en, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that mestions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Long-chain fatty acid oxidation disorder (LC-FAOD)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Prescriber Signature		Date



EOC ID:

Dronabinol-2 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
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 request	ed 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 a	anti-cancer chemotherapeutic regi	men?
☐ Yes	□ No	
Q7. Is the oral drug being used as a full therapeutic replac within 48 hours of chemotherapy?	ement for an intravenous anti-nau	sea drug administered
Yes	□ No	



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



EOC ID:

Dupixent-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 patier	nt:	
☐ 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 n	nedication being used as adjunct t	reatment?
·		TOGUMONE:
Yes	☐ No	



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 ar high potency topical corticosteroids (e.g., mometasone, trial	nd failure, contraindication, or intolerance to two medium to amcinolone, fluocinolone, betamethasone, etc.)?	
☐ Yes	□ No	
Q8. If the patient has NOT tried any topical corticosteroi (i.e., contraindication, history of adverse event, etc.)?	ds, is there a reason why these medications cannot be used	
Q9. Is the requested medication prescribed by or in consultation with an allergist, dermatologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist?		
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Enbrel-2 Medicare

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

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 writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information	for this patient that may support a	approval. Please answer the	
	estions and sign.	T	
Q1. Is this request for initial or continuing therapy?			
Initial therapy	Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed 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	helow:		
Q4. If the patient's diagnosis is 6 TTEN, please specify	bolow.		
Q5. For PLAQUE PSORIASIS, is the patient a candidate for phototherapy?	or systemic therapy (such as the r	requested medication) or	
☐ Yes	☐ No		
Q6. Has the patient been screened for latent tuberculosis	infection prior to initiation of treatm	nent?	
Yes	□ No		
	<u> </u>		



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	



EOC ID:

Endari-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 m	edication being used in combinati	on with recombinant
human growth hormone?		
☐ Yes	□ No	
Q6. Is the patient 5 years of age or older?		
☐ Yes	□ No	



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



EOC ID:

Enspryng-3 Medicare

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

Patient Name:	Prescriber Name:	
		Dhana
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
Group Number:	NPI:	State Lic ID:
Address:	Address:	Cidio Elo ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if appl	licable):
*Please note that Elixir will process the request as writte	en, including drug name, w	vith 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 request	ed 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	ve?	
☐ 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.)		



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



EOC ID:

Entresto-3 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following quantum followi	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Chronic heart failure		
Symptomatic heart failure		
Other		
Q4. For CHRONIC HEART FAILURE, does the patient have failure?	ve New York Heart Association (N	YHA) class II-IV heart
☐ Yes	□ No	
Q5. For SYMPTOMATIC HEART FAILURE, does the patie	ent have systemic left ventricular s	ystolic dysfunction?
☐ Yes	☐ No	
Q6. Does the patient have any of the following? (Please se	elect all that apply.)	
☐ History of angioedema related to previous ACE inhit	oitor 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		



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	



EOC ID:

Epidiolex-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Fhone.
Group Number:	NPI:	State Lic ID:
Address:	Address:	State LIC ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f annlicable):
*Please note that Elixir will process the req		
Trouse note that Linkii will process the req		<u> </u>
Drug Name and Strength:	☐ Expedited/Urg	ent
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	or the requested medication:	
Lennox-Gastaut syndrome		
☐ Seizures associated with tuberous sclero	osis complex	
☐ Severe myoclonic epilepsy in infancy (Di☐ Other	ravet syndrome)	
Q4. If the patient's diagnosis is OTHER, p	lease specify below:	
Q5. Is the requested medication prescribed I	by or in consultation with a neurologis	t?
☐ Yes	□ No	
Prescriber Signature		Date



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:

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EOC ID:

Epoetin Therapy-2 Medicare

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

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 nam	e (if applicable):
*Please note that Elixir will process the request as writte	en, including drug r	name, with no substitution.
	☐ Expedited/L	Jrgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that r	may support approval. Please answer the
	estions and sign.	· · · · · · · · · · · · · · · · · · ·
Q1. Is this request for initial therapy or continuing therapy?	· · · · · · · · · · · · · · · · · · ·	
		havanu
☐ Initial therapy	Continuing t	nerapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Anemia associated with chronic kidney disease (CKD)	. on dialvsis	
☐ Anemia associated with chronic kidney disease (CKD)	•	
☐ Anemia associated with myelosuppressive chemothera	•	
☐ Anemia associated with zidovudine therapy in a patien	• •	
☐ Reduction of blood transfusions in a patient undergoin		ac. non-vascular surgery who is at high
risk for perioperative blood loss	g,	,g
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	holow:	
Q4. If the patient's diagnosis is OTTIEN, please specify	below.	
	40 / 11 0	
Q5. Is the patient's pre-treatment hemoglobin level less that	an 10 g/dL?	
Yes	☐ No	
Q6. Will there be a dose reduction or interruption if hemog	lobin exceeds one of	the following: 10 g/dL (adult CKD not
on dialysis, or cancer), 11 g/dL (CKD on dialysis), or 12 g/d		5 - 2 3 - 2 (2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-



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



EOC ID:

Erleada-1 Medicare

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

Patient Name:	Prescriber Name:	
		Dharas
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lic ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as writt		
Trease note that Linxii will process the request as write	Expedited/U	·
Drug Name and Strength:	,	
Directions / SIG:		
Plane attack and made at the list and a sinfamonia	or for this work and that w	Discount and a second
Please attach any pertinent medical history or informatio following qu	n for this patient that nuestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ted 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 consu	ultation with an oncolo	gist or urologist?
☐ Yes	□No	
Describe C' :		Dete
Prescriber Signature		Date



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:



EOC ID:

Erlotinib-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Filolie.
Group Number:	NPI:	State Lic ID:
Address:	Address:	01010 210 121
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	□ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
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 requeste	ed medication:	
│ │ │ │ │ Non-small cell lung cancer (locally advanced or metast	catic)	
☐ Pancreatic cancer (locally advanced, unresectable or r	· ·	
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For NON-SMALL CELL LUNG CANCER, please selec	at all that apply to the patient:	
☐ The patient has epidermal growth factor receptor (E		1 (L858R) substitution
mutation as detected by a FDA-approved test or Clinical L facility	,	` '
☐ The requested medication will be used as first-line tr	reatment	
☐ The patient had failure with at least one prior chemo		
☐ The patient has no evidence of disease progression	after four cycles of first-line platinu	ım-based chemotherapy
and the requested medication will be used as maintenance treatment		
☐ None of the above		



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 consult	tation with an oncologist?
☐Yes	□ No
Prescriber Signature	Date



EOC ID:

Everolimus-1 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a	approval. Please answer the
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 requeste	ed medication:	
☐ Advanced hormone receptor-positive, human epiderma☐ Advanced renal cell carcinoma	al growth receptor 2 (HER2)-nega	ative breast cancer
☐ Progressive, well-differentiated, nonfunctional neuroen unresectable, locally advanced, or metastatic	docrine tumors of gastrointestina	I (GI) or lung origin,
☐ Pancreatic progressive neuroendocrine tumors, unrese	ectable, locally advanced, or meta	astatic
Renal angiomyolipoma and tuberous sclerosis complex	x (TSC) not requiring immediate s	surgery
☐ Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC)☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify l	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 anastro	ozole (Arimidex)	



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 f	ailure 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	



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 a	s written, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or info	rmation for this nationt that ma	av sunnort annroval. Please answer the
	wing questions and sign.	ay support approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
.,		
Q2. For CONTINUING THERAPY, please provid	le the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the r	equested medication:	
☐ Spinal muscular atrophy (SMA)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please s	specify below:	
Q5. Is the requested medication prescribed by or in	consultation with a neurologi	st?
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Farydak-2 Medicare

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

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	e):
*Please note that Elixir will process the request as writt	en, including drug name, with ı	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following quantum followi	n for this patient that may support lestions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Multiple myeloma	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the requested medication being used in combinatio	n with bortezomib (Velcade) and	dexamethasone?
☐ Yes	□ No	
Q6. Has the patient received at least two prior treatment re immunomodulatory agent [e.g., lenalidomide (Revlimid), the	•	elcade) and an
☐ Yes	□ No	
Q7. If the patient has NOT tried any of the medications medications cannot be used (i.e., contraindication, history)		there a reason why these



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	



EOC ID:

Fentanyl Oral-1 Medicare

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

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 writte	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
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 requeste	ed 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 aroun	d-the-clock opioid therapy for pers	sistent cancer pain?
☐ Yes	□ No	
Q6. Are the patient and prescriber enrolled in the Transmu Mitigation Strategy (REMS) Access Program?	cosal Immediate Release Fentany	/I (TIRF) Risk Evaluation
☐ 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 fo	ollowing? (Please select all that ap	pply.)



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 room) ☐ Use in an opioid non-tolerant patient ☐ None of the above 	ng headache/migraine, dental pain, or use in the emergency
Prescriber Signature	Date



EOC ID:

Fintepla-1 Medicare

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

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 w	ritten, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	ation for this patient that may	ay support approval. Please answer the
	, 4400	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the	ne start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	ested medication:	
Severe myoclonic epilepsy in infancy (Dravet syndrome)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spec	cify below:	
Q5. Is the requested medication prescribed by or in co	nsultation with a neurologi	st?
☐ Yes	☐ No	
Q6. Is the patient using the requested medication cond 14 days of discontinuing a MAOI?	comitantly with a monoami	ne oxidase inhibitor (MAOI) or within
☐ Yes	☐ No	
		
Prescriber Signature		Date



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:
This telecopy transmission contains confidential information belonging to the sender the	hat is legally privileged. This information is intended only for the use of the individual



EOC ID:

Firazyr-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	THORE.
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 reque	est as written, including drug nam	e, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or f	information for this patient that may ollowing questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing thera	py?	
☐ Initial therapy	☐ Continuing then	ару
Q2. For CONTINUING THERAPY, please pr	rovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for t	the requested medication:	
☐ Hereditary angioedema	☐ Other	
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Will the requested medication be used for the	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 hematologi	st, immunologist, or allergist?
☐ Yes	□No	



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



EOC ID:

Firdapse-1 Medicare

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

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 wri	tten, including drug na	ame, with no substitution.
	☐ Expedited/U	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati following of	on for this patient that m questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Lambert-Eaton myasthenic syndrome (LEMS)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	y 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



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:

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EOC ID:

Fotivda-1 Medicare

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

Patient Name:	Prescriber Name:		
		D.	
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:	Otata Lin ID	
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:	75 P. 11 N	
Primary Phone:	Specialty/facility name	(if applicable):	
*Please note that Elixir will process the request as write	ten, including drug na	me, with no substitution.	
	☐ Expedited/Urg	gent	
Drug Name and Strength:			
Dispetieure / OIO			
Directions / SIG:			
Please attach any pertinent medical history or informatio	n for this patient that ma	ay support approval. Please answer the	
	uestions and sign.		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	py Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Α, μ	(
Q3. Please indicate the patient's diagnosis for the request	ted 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 the	rapies?		
☐ Yes	□ No		
Q6. If the patient has NOT tried 2 or more prior system	ic therapies, is there a r	reason why these medications cannot	
be used (i.e., contraindication, history of adverse event, etc.)?			



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 consul	tation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Galafold-1 Medicare

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

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 (i	f applicable):
*Please note that Elixir will process the re	equest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	y support approval. Please answer the
O1 to this request for initial or continuing t	thorony?	
Q1. Is this request for initial or continuing t	<u></u>	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, plea	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s 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 ga	alactosidase alpha gene (GLA) mutatior	n?
☐ Yes	□ No	
Q6. Is the patient 16 years of age or older	?	
☐ Yes	□ No	
Prescriber Signature		Date



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:



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 na	nme, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform following	nation for this patient that mang	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the rec	nuested medication:	
☐ Short bowel syndrome	☐ Other	
Q4. If the patient's diagnosis is OTHER, please sp	ecify below:	
Q5. Is the patient dependent on parenteral nutrition?		
☐ Yes	□No	
Prescriber Signature		Date



EOC ID:

Gavreto-2 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
- .	<u> </u>	
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 requeste	ed 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 bel	ow:	
Q5. FOR NON-SMALL CELL LUNG CANCER, was the pa	tient's diagnosis detected by a FD	A-approved test?
·	_	r approved toot.
Yes	☐ No	
Q6. FOR THYROID CANCER, please select all that apply	to the patient:	
$\hfill\Box$ The patient requires systemic therapy (such as the r	equested medication)	
☐ The patient is radioactive iodine-refractory, when radioactive iodine is appropriate		
☐ None of the above		



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 consul	tation with an oncologist?
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Gilotrif-2 Medicare

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

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 writt	ten, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following quarters of the control of	n for this patient that ma	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the request	ted 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 ☐ None of the above	n after platinum-based o	chemotherapy
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by or in consu	ultation with an oncologi	st?
☐ Yes	☐ No	



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	



EOC ID:

Gocovri-1 Medicare

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

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 requ	uest as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that ma following questions and sign.	y support approval. Please answer the
	Tonowing questions and sign.	
Q1. Is this request for initial or continuing the	rapy?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis fo	r the requested medication:	
Extrapyramidal disease	The requested medication.	
Parkinson's disease		
Other		
Q4. If the patient's diagnosis is OTHER, pl	ease specify below:	
Q5. For PARKINSON'S DISEASE, please se	lect all that apply to this nationt:	
_	iect aii that apply to this patient.	
☐ Patient is experiencing dyskinesia☐ Patient is receiving levodopa-based the	erany	
None of the above	стару	
Q6. Does the patient have a documented tria	I and failure of amantadine immediat	te release?
☐ Yes	□No	
Q7. If the patient has NOT tried amantadin	e immediate release, is there a reas	on why this medication cannot be used



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:
(i.e., contraindication, history of adverse event, etc.)?	
Q8. Is the requested medication prescribed by or in consul	tation 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



EOC ID:

Growth Hormone-1 Medicare

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

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 writte	en, 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 a	oproval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
	,	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
<u>_</u>	☐ Prader-Willi syndrome, ped	iatric
Chronic renal insufficiency (CRI), pediatric	☐ Short-stature homeobox-co	
Growth hormone deficiency (GHD), adult	deficiency, pediatric	maining gone (or row,)
Growth hormone deficiency (GHD), pediatric	☐ Small for gestational age (S	GA), pediatric
☐ Idiopathic short stature, pediatric	☐ Turner syndrome	,···
☐ Noonan syndrome, pediatric	Other	
Q4. If the patient's diagnosis is OTHER, please specify by	pelow.	
Q4. If the patient's diagnosis is Official, piease speeily i	ociow.	
Q5. For CHRONIC RENAL INSUFFICIENCY, please selec	t all that apply to the patient:	
·	тап тпат арргу то тпе рапетт.	
☐ Nutritional status has been optimized		
☐ Metabolic abnormalities have been corrected		
☐ The patient has not had renal transplant		
☐ None of the above		



EOC ID:

Growth Hormone-1 Medicare

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

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 confirm	ned 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 (GI	HD), 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		



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, ple the patient underwent below.	ease provide the growth hormone (GH) stimulation tests that	
Q13. Is the requested medication prescribed by or in const	ultation with an endocrinologist or nephrologist?	
☐ Yes	□ No	
Q14. Does the patient have any of the following? (Please s	select all that apply.)	
	promotion in pediatric patients with closed epiphyses ng open-heart or abdominal surgery, multiple accidental	
Active proliferative or severe non-proliferative diabet	· · · ·	
Prader-Willi Syndrome in patients who are severely apnea, or have severe respiratory impairment	obese, have a history of upper airway obstruction or sleep	
☐ None of the above		
Prescriber Signature		



EOC ID:

Hepatitis C-1 Medicare

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

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 writte	en, including drug name, with no	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:	•		
Directions / SIG:			
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the	
<u> </u>	<u> </u>		
Q1. Is this request for initial or continuing therapy?			
	По :: : : : : : : : : : : : : : : : : :		
☐ Initial therapy	Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Chronic Hepatitis C	Other		
Q4. If the patient's diagnosis is OTHER, please specify l	pelow.		
an in the patiente diagnosis is entirely, please speenly.			
Q5. Please provide the patient's genotype, subtype and que therapy:	antitative HCV RNA (viral load) te	sting any time prior to	
Q6. Has the prescriber documented the following within 12 panel, and GFR?	weeks of initiating therapy: CBC,	INR, hepatic function	
☐ Yes	□ No		
Q7. Is the patient post-transplant?			
☐ Yes	□ No		



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 consapply)? Gastroenterologist Hepatologist Infectious Disease Specialist None of the above	sultation with, one of the following (please select any that
Q12. For Vosevi: Has the patient had trial and failure, cont Sofosbuvir/Velpatasvir (Epclusa)?	raindication, or intolerance to Mavyret or
☐ Yes ☐ No	□ N/A
Q13. If the patient has NOT tried any of the medications medications cannot be used (i.e., contraindication, histo	listed in the previous question, is there a reason why these ry of adverse event, etc.)?
Prescriber Signature	Date



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 (i	f applicable):
*Please note that Elixir will process the r	request as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical histo	ory or information for this patient that ma	y support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, plea	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s 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



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	e):
*Please note that Elixir will process the request as writt	en, including drug name, with r	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support estions and sign.	approval. Please answer the
	<u> </u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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



EOC ID:

Humira-2 Medicare

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

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 writte	n, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a stions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
│	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	d medication:	
☐ Ankylosing spondylitis	☐ Polyarticular juvenile idiopa	athic arthritis, moderate to
☐ Crohn's disease, moderate to severe	severe	
☐ Hidradenitis suppurativa, moderate to severe	☐ Psoriatic arthritis	
☐ Non-infectious uveitis (including intermediate, posterior	, 🔲 Rheumatoid arthritis, mode	erate to severe
and panuveitis)	☐ Ulcerative colitis, moderate	e to severe
☐ Plaque psoriasis, moderate to severe chronic	Other	
Q4. If the patient's diagnosis is OTHER, please specify b	pelow.	
a in it are parterned diagnostic to a finality product opening a		
Q5. For CROHN'S DISEASE, has the patient had an inade	quate response to conventional t	herapy?
☐ Yes	☐ No	
Q6. For PLAQUE PSORIASIS, is the patient a candidate for	or systemic therapy or photothera	pv. and are other systemic
therapies medically less appropriate?	-, p , p	1 7, 2.1.2 2.1.2 2.1.3. 2,3.3
☐ Yes	□ No	
	_	



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 inacorticosteroids, azathioprine)?	adequate response to immunosuppressants (e.g.,	
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 i	nfection prior to initiation of treatment?	
Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Ibrance-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the	
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 requeste	ed 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)-positiv negative?	re, human epidermal growth factor	receptor 2 (HER2)-	
☐ Yes	☐ No		
Q6. Please indicate how the requested medication will be	used:		
☐ In combination with an aromatase inhibitor in a post	menopausal woman or man		
☐ In combination with fulvestrant (Faslodex) for diseas ☐ None of the above	se progression following endocrine	therapy	
Q7. Is the patient 18 years of age or older?			
☐ Yes	□ No		



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	□ No	
Prescriber Signature	 Date		



EOC ID:

Iclusig-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Chronic myeloid leukemia (CML), chronic, accelerated		
☐ Philadelphia chromosome-positive acute lymphoblastic ☐ 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	



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 consu	ultation with an oncologist or hematologist?
☐ Yes ☐ No	
Prescriber Signature	 Date



EOC ID:

Idhifa-1 Medicare

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

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 writte	en, including drug na	ame, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that mestions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Acute myeloid leukemia (AML), relapsed or refractory	/ ☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify I	pelow:	
Q5. Does the patient have an isocitrate dehydrogenase 2 r	nutation as detected b	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 consul	tation with an oncolog	jist or hematologist?
☐ Yes	☐ No	



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



EOC ID:

Imbruvica-2 Medicare

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

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 applic	able):
*Please note that Elixir will process the request as writte	en, including drug name, wit	h no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may supposestions and sign.	ort approval. Please answer the
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 requeste	ed 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 17	p deletion	
☐ Waldenstrom macroglobulinemia		
Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For GRAFT-VERSUS-HOST DISEASE, has the patien	nt failed at least one first-line o	orticosteroid therapy?
☐ Yes	☐ No	
Q6. For MANTLE CELL LYMPHOMA, has the patient rece	eived at least one prior therapy	?
☐ Yes	☐ No	



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:		
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-ba	ased therapy		
None of the above			
Q8. If the patient has NOT tried any of the medications list medications cannot be used (i.e., contraindication, history	ted in the previous question(s), is there a reason why these of adverse event, etc.)?		
Q9. Is the patient 18 years of age or older?			
☐ Yes	□ No		
Prescriber Signature	Date		



EOC ID:

Inbrija-1 Medicare

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

Deticut Names	Dresseih av Names	
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 (i	if applicable):
*Please note that Elixir will process the request as write	en, including drug nar	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this patient that mag	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Parkinson's disease	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Will the requested medication be used concurrently w	rith carbidopa/levodopa?	•
Yes	☐ No	
Q6. Has the patient tried and failed or has a contraindicat	on to one generic formu	lary alternative?
☐ Yes	☐ No	
Q7. If the patient has NOT tried one generic formulary a contraindication, history of adverse event, etc.)?	alternative, is there a rea	ason why it cannot be used (i.e.,
Q8. Is the patient 18 years old or older?		



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 so Concurrent use with nonselective monoamine oxidate Recent use (within 2 weeks) with a nonselective MA None of the above	se inhibitor (MAOI) (e.g., phenelzine or tranylcypromine)
Prescriber Signature	Date



EOC ID:

Increlex-1 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with I	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:	. •	
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support estions and sign.	approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
_ ·	Continuing the game	
☐ Initial therapy	Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 se	elect all that apply.)	
☐ Severe primary insulin-like growth factor-1 (IGF-1) d	eficiency	
☐ 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 pat	ient:	
☐ 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		



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



EOC ID:

Inqovi-1 Medicare

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

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 writte	en, including drug name, with no	substitution.	
Drug Name and Strength:	☐ Expedited/Urgent		
Directions / SIG:			
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the	
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 requeste	ed 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 consul	tation with an oncologist?		
☐ Yes	□ No		



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:	Prescribe	Name:
	•	
Prescriber Signature		Date



EOC ID:

Inrebic-2 Medicare

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

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	n, including drug na	ame, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that m stions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the sta	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requested	d modication:	
☐ Intermediate-2 or high-risk primary or secondary (post polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF)	t- ☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify b	elow:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Is the requested medication prescribed by or in consult	ation with an oncolog	ist or hematologist?
☐ Yes	☐ No	
Prescriber Signature		Date



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:
This telecopy transmission contains confidential information belonging to the sender the	nat is legally privileged. This information is intended only for the use of the individ



EOC ID:

Intrarosa-1 Medicare

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

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 req	uest as written, including drug nam	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	егару?	
☐ Initial therapy	☐ Continuing ther	тару
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	or the requested medication:	
☐ Moderate to severe dyspareunia due to	menopause	
☐ Atrophic vaginitis due to menopause☐ Other	'	
Q4. If the patient's diagnosis is OTHER, p	lease specify below:	
Q5. Is the patient 18 years of age or older?		
Q5. Is the patient 18 years of age or older?	□No	
☐ Yes	ng? (Please select all that apply.)	



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



EOC ID:

Iressa-1 Medicare

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

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 writ	tten, including drug na	ame, with no substitution.
	☐ Expedited/Ui	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that m juestions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Does the patient's tumor have epidermal growth fact substitution mutations as detected by a FDA-approved to facility?	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·
☐ Yes	☐ No	
Q6. Is the requested medication being used as first-line t	reatment?	
☐Yes	☐ No	
Prescriber Signature		Date



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:



EOC ID:

Isturisa-2 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
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 reque	est as written, including drug nam	e, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history of	r information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing thera	ру?	
☐ Initial therapy	☐ Continuing there	ару
Q2. For CONTINUING THERAPY, please p	rovide 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, plea	ase specify below:	
Q5. Is pituitary surgery not an option or has no	t 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 endocrino	logist?
☐ Yes	□No	



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



EOC ID:

Itraconazole-1 Medicare

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

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	e (if applicable):
*Please note that Elixir will process the request as writ	ten, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that nuestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the drug that is being requested belo	w:	
☐ Itraconazole capsules	☐ Itraconazole	solution
Q4. Please indicate the patient's diagnosis for the reques	ited medication:	
☐ Candidiasis (esophageal or oropharyngeal)		
Onychomycosis		N
☐ Systemic fungal infection (e.g., aspergillosis, histopla: ☐ Other	smosis, diastomycosis)
Q5. If the patient's diagnosis is OTHER, please specify	/ below:	
Q6. For CANDIDIASIS, is the disease refractory to treatm	nent with fluconazole?	
☐Yes	□No	
Q7. If the patient has NOT tried fluconazole, is there a contraindication, history of adverse event, etc.)?	reason why this medic	eation cannot be used (i.e.,



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 culture, or nail biopsy?	by positive potassium hydroxide (KOH) preparation, fungal
☐ Yes	□ No
Q9. Does the patient have any of the following? (Please se	elect all that apply.)
Uentricular dysfunction (e.g., congestive heart failure	e [CHF] or history of CHF)
☐ Concurrent therapy with a CYP3A4 substrate (e.g.,	methadone, lovastatin, simvastatin, etc.)
☐ None of the above	
Prescriber Signature	Date



EOC ID:

IVIG-1 Medicare

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

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 applical	ole):	
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following que	n for this patient that may suppor estions and sign.	t approval. Please answer the	
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 requeste	ed medication:		
☐ Chronic inflammatory demyelinating polyneuropathy (C	CIDP)		
☐ Idiopathic or chronic immune thrombocytopenic purpur			
☐ Motor neuropathy with multiple conduction block			
☐ Prevention of bacterial infection in patients with hypogachronic lymphocytic leukemia (CLL)	ammaglobulinemia or recurrent	bacterial infections with B-cell	
☐ Prevention of coronary artery aneurysms associated w	rith 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 se	elect all that apply.)		
☐ History of anaphylaxis or severe systemic reaction to	o human immune globulin		
☐ IgA deficiency with antibody formation and a history	of hypersensitivity		



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 dise D83.9; D82.0; D81.0; D81.1; D81.2; D81.89; D81.9; G11.3 D82.1; D82.4; D83.0; D83.1; D83.2)	ease? (One of these ICD-10 codes: D80.0; D80.5; D83.8; B; D80.2; D80.3; D80.4; D80.6; D80.7; D81.5; D81.6; D81.7;
☐ Yes	□ No
Q7. Is the medication being administered in the patient's h	ome?
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Jakafi-1 Medicare

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

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 appl	icable):
*Please note that Elixir will process the request as writte	en, including drug name, w	ith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may sup estions and sign.	port approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
 ☐ Acute graft-versus-host disease ☐ Intermediate or high risk myelofibrosis, including prima post-essential thrombocythemia myelofibrosis ☐ Polycythemia vera ☐ Other 	ıry myelofibrosis, post-polycy	rthemia vera myelofibrosis and
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For GRAFT-VERSUS-HOST DISEASE, is the disease	e refractory to steroid therapy	?
☐ Yes	□ No	
Q6. For POLYCYTHEMIA VERA, has the patient had an in	nadequate response to or is i	ntolerant to hydroxyurea?
☐ Yes	□ No	
Q7. If the patient has NOT tried hydroxyurea, is there a	reason why this medication of	cannot be used (i.e.,



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	



EOC ID:

Juxtapid-2 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		approval. Please answer the
following que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 t	he following? (Please select all the	nat apply.)
☐ Genetic confirmation of 2 mutations in the LDL reception	• ,	,
(LDLRAP1 or ARH)	·	
☐ The patient has untreated LDL-C greater than 500 m	ng/dL or treated LDL-C greater the	an 300 mg/dL
☐ Xanthoma before 10 years of age		
Evidence of heterozygous familial hypercholesterole	mia in both parents	
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
Yes	□ No	



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 pat	ient:
☐ 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	



EOC ID:

Kalydeco-1 Medicare

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

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 r	equest as written, including drug naı	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that ma following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing	herapy?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, plea	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s 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 responsive to ivacaftor potentiation based		ctance regulator (CFTR) gene that is
Yes	□ No	
Q6. Is the requested medication prescribe from a CF center accredited by the Cystic	•	gist or is the prescribing practitioner
Yes	□ No	
Prescriber Signature		



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:



EOC ID:

Kesimpta-1 Medicare

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

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)	e):
*Please note that Elixir will process the request as writte	en, including drug name, with I	10 substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Discretions (OIO)		
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 requeste	ed 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 feature	,	osis
☐ 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 consu	Itation with a neurologist?	
☐ Yes	□ No	
Q7. Does the patient have active hepatitis B infection?		
Yes	□ No	
	□ 140	



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		



EOC ID:

Kisqali-1 Medicare

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

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 writte	en, 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 s	tart date (MM/YY):	
Q3. Please indicate which medication this request is for be	elow:	
☐ Kisqali	☐ Kisqali Femara	
Q4. Please indicate the patient's diagnosis for the requeste	ed 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)-positiv negative?	re, human epidermal growth factor	receptor 2 (HER2)-
☐ Yes	□ No	
Q7. Please indicate the patient's menopause status:		
☐ The patient is postmenopausal		
☐ The patient is premenopausal or perimenopausal		
☐ None of the above		



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	



EOC ID:

Korlym-1 Medicare

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

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	e (if applicable):
*Please note that Elixir will process the request as write	ten, including drug n	ame, with no substitution.
	☐ Expedited/U	Irgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	on for this patient that nuestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	herapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted 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 ☐ The requested medication is being used to control ☐ The patient has failed surgery ☐ The patient is not a candidate for surgery 		dary to hypercortisolism
☐ 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 consu	ultation with an endocr	rinologist?



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		
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	



EOC ID:

Koselugo-2 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	THORE.
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	t as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or in follows:	formation for this patient that may lowing questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy	?	
☐ Initial therapy	☐ Continuing ther	тару
Q2. For CONTINUING THERAPY, please prov	vide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	e requested medication:	
☐ Neurofibromatosis type 1 (NF1)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please	e specify below:	
Q5. Does the patient have symptomatic, inoperal	ble 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 oncologis	t?
☐ Yes	☐ No	



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



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 nar	ne (if applicable):	
*Please note that Elixir will process the request as writte	n, 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 sta	art date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU	J) Dther		
Q4. If the patient's diagnosis is OTHER, please specify b	pelow:		
Prescriber Signature		Date	



EOC ID:

Lenvima-1 Medicare

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

	<u> </u>		
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 (i	f applicable):	
*Please note that Elixir will process the red	quest as written, including drug nar	ne, with no substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Places attach any partinent medical history	v or information for this nations that ma	v cumpert approval. Please answer the	
Please attach any pertinent medical history	following questions and sign.	y support approval. Please answer the	
Q1. Is this request for initial or continuing the	erapy?		
☐ Initial therapy	☐ Continuing the	rapy	
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis f	for the requested medication:		
☐ Endometrial carcinoma, advanced			
Locally recurrent or metastatic, progress	sive, radioactive iodine-refractory diffe	rentiated thyroid cancer	
Renal cell carcinoma, advanced	·	•	
☐ Unresectable hepatocellular carcinoma,	first-line therapy		
☐ Other			
Q4. If the patient's diagnosis is OTHER, p	blease specify below:		
,,	, ,		
Q5. For ENDOMETRIAL CARCINOMA, plea	ase select all that apply to this patient:		
	☐ The patient's disease is NOT microsatellite instability-high or mismatch repair deficient		
	ed in combination with pembrolizumab		
☐ The patient's disease has progressed	·	() 222)	
☐ The patient is not a candidate for curative surgery or radiation			
☐ None of the above	3 ,		



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	



EOC ID:

Leukine-1 Medicare

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

Patient Name:	Prescriber Name:	
	riescriber 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 reque	est as written, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or	information for this patient that ma ollowing questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing thera	ру?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please pr	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for t	he requested medication:	
Acute myeloid leukemia, following completi	on of induction chemotherapy	
☐ Allogeneic or autologous bone marrow tran		ent
☐ Autologous peripheral blood progenitor cell☐ Autologous peripheral blood stem cell trans		•
Hematopoietic subsyndrome of acute radia	, • ,	етюшетару
Myeloid reconstitution after autologous or a	, ,	
Other	mogencie bone marrow transpiant	
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Prescriber Signature		Date



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:

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EOC ID:

Leuprolide-2 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Anemia due to uterine leiomyomata (fibroids), preopera	ative	
☐ Central precocious puberty (idiopathic or neurogenic) i	n 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 history of adverse event, etc.)?	n why this medication cannot be u	used (i.e., contraindication,
Q7. Will this medication be administered in a physician's o	ffice?	



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.

П	
their stock?	
□ No	
□ No	



FOC 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 reques	t as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	jent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or i	nformation for this patient that ma llowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therap	y?	
☐ Initial therapy	☐ Continuing the	егару
Q2. For CONTINUING THERAPY, please ind	icate the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for th	e requested medication:	
☐ Pain associated with cancer-related neuropa	athy	
☐ Pain associated with diabetic peripheral neu	•	
☐ Postherpetic neuralgia	, ,	
☐ Back pain		
☐ Osteoarthritis of the knee or hip		
☐ Other		
Q4. If the patient's diagnosis is OTHER, pleas	se specify below:	
Prescriber Signature		Date



EOC ID:

Lonsurf-1 Medicare

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

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 application)	able):
*Please note that Elixir will process the request as writte	en, including drug name, wit	h no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Di di (010		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may suppo	ort approval. Please answer the
following qu	estions 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 requeste	ed 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 F	RAS wild-type?	
Yes	□ No	
Q6. For COLORECTAL CANCER, has the patient been pr that apply.)	eviously treated with any of the	e following? (Please select all
☐ Anti-EGFR therapy		
☐ Anti-VEGF therapy		
☐ Fluoropyrimidine-, oxaliplatin- and irinotecan-based	chemotherapy	
☐ None of the above		



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 I medications cannot be used (i.e., contraindication, histo	isted in the previous question, is there a reason why these ry of adverse event, etc.)?
Q8. For GASTRIC OR GASTROESOPHAGEAL JUNCTIO treated with at least 2 prior lines of chemotherapy that incluirinotecan, and if appropriate, HER2/neu-targeted therapy?	uded a fluoropyrimidine, a platinum, either a taxane or
Yes	□ No
Q9. Is the patient 18 years of age or older?	
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Lorbrena-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	Other	
Mon-small cell lung cancer (NGCLC), metastatic		
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 apply.)	following for metastatic disease?	(Please select all that
☐ 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 the	nere a reason why these



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:	
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 consul	tation with an oncologist?	
☐ Yes	□ No	
Q10. Will the requested medication be used concomitantly with strong CYP3A4 inducers?		
☐ Yes	□ No	
Prescriber Signature		



EOC ID:

Lumakras-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Non-small cell lung cancer (NSCLC), KRAS G12C-mutated locally advanced or metastatic	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Has the KRAS G12C mutation been determined by an	FDA-approved test?	
☐ Yes	□ No	
Q6. Has the patient received at least one prior systemic the	erapy?	
☐ Yes	□ No	
Q7. If the patient has NOT tried at least one prior system	nic therapy, is there a reason why	these medications cannot



EOC ID:

Lumakras-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:	
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 being prescribed by or in	consultation with an oncologist?	
☐ Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Lupkynis-1 Medicare

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

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 writt	en, including drug na	ame, with no substitution.	
	☐ Expedited/U	rgent	
Drug Name and Strength:	·		
Directions / SIG:			
Please attach any pertinent medical history or information following qu	n for this patient that m	ay support approval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing th	erapy	
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the request	ed 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 t	o 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:		
don't don't don't direct in 1, ploade delete all that	apply to the patient.		



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:	
☐ The patient had improvement in urine protein to crea ☐ The patient has an estimated glomerular filtration ra confirmed decrease from baseline in eGFR of greater than ☐ None of the above	te (eGFR) of 60 mL/min/1.73 m2 or greater, or there is no	
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 itraconazole, clarithromycin)?	with strong CYP3A4 inhibitors (e.g., ketoconazole,	
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Lynparza-2 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	i for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 al	Il that apply to this patient:	
☐ The patient has known or suspected BRCA mutation		test
☐ The patient has trial and failure, contraindication, or	•	
☐ None of the above		. c. chomosiorapy
_	this matient.	
Q6. For BREAST CANCER, please select all that apply to	tnis patient:	



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.**

atient 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 F apply to this patient:	PRIMARY PERITONEAL CANCER, please select all that	
☐ The cancer is recurrent ☐ The cancer is advanced		
☐ The requested medication is being used for mainten response to platinum-based chemotherapy (e.g., cisplatin	ance treatment in a patient who is in complete or partial , carboplatin)	
☐ The patient has deleterious or suspected deleterious☐ The patient is in complete or partial response to first	s germline or somatic BRCA mutation (gBRCAm or sBRCAm) -line platinum-based chemotherapy	
☐ The cancer is associated with homologous recombined deleterious or suspected deleterious BRCA-mutation, and	nation deficiency positive status defined by either a	
☐ The requested medication is being used in combination. ☐ None of the above	tion with bevacizumab (Avastin) for maintenance treatment	
Q8. For PANCREATIC ADENOCARCINOMA, please selection	ct all that apply to this patient:	
☐ The patient has deleterious or suspected deleterious	s 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	



EOC ID:

Mayzent-1 Medicare

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

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 applica	ble):	
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following qu	n for this patient that may suppo estions and sign.	rt approval. Please answer the	
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 request	ed medication:		
Relapsing forms of multiple sclerosis (including			
clinically isolated syndrome, relapsing-remitting disease, or			
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Has the patient had history of or contraindication to ar	ny of the following? (Please sele	ect all that apply.)	
Avonex			
Betaseron			
Cilonyo			
☐ Gilenya ☐ Tecfidera			
None of the above			
Q6. If the patient has NOT tried any of the medications medications cannot be used (i.e., contraindication, history)		s there a reason why these	



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:		
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q8. Is the requested medication prescribed by or in consul	tation 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 inffailure requiring hospitalization, or Class III-IV heart failure	arction, unstable angina, stroke, TIA, decompensated heart	
	ree AV block, or sick sinus syndrome, unless the patient has	
a functioning pacemaker	,	
☐ None of the above		
Prescriber Signature	 Date	



EOC ID:

Mekinist-2 Medicare

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

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	e (if applicable):	
*Please note that Elixir will process the request as write	ten, including drug n	ame, with no substitution.	
	☐ Expedited/L	Irgent	
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 t	herapy	
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	ted medication:		
Anaplastic thyroid cancer, locally advanced or metast	atic		
☐ 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 pati	ient have no locoregio	nal treatment options?	
☐ Yes	☐ No		
Q6. For ANAPLASTIC THYROID CANCER OR NON-SM V600E mutation?	ALL CELL LUNG CAN	NCER, does the patient have BRAF	
☐ Yes	☐ No		
Q7. For MALIGNANT MELANOMA, please select all that	apply to this patient:		



EOC ID:

Mekinist-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 has BRAF V600E or V600K mutations ☐ The patient has lymph node involvement, following of ☐ The patient's disease is unresectable or metastatic ☐ The requested medication will be used as monother. ☐ 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



EOC ID:

Mektovi-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the star	t date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 V	600K mutation as detected by a F	DA-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 consul	tation with an oncologist?		
☐ Yes	□ No		



EOC ID:

Mektovi-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		



EOC ID:

Methylphenidates-1 Medicare

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

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 nam	ne (if applicable):
*Please note that Elixir will process the request as writte	en, including drug i	name, with no substitution.
	☐ Expedited/	Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that estions and sign.	may support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing	therapy
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ad medication:	
	ed medication.	
☐ Attention deficit hyperactivity disorder (ADHD)☐ Narcolepsy		
☐ Other		
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 justifi	cation:	
Q7. Does the patient have any of the following? (Please se	elect all that apply.)	



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 p ☐ Concurrent use with MAOIs ☐ None of the above	resence of motor tics
Prescriber Signature	Date



EOC ID:

Miglustat-1 Medicare

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

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 wri	tten, including drug na	ame, with no substitution.
	☐ Expedited/U	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following of	on for this patient that m questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Gaucher disease, type 1 (mild to moderate)	Other	
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Is the patient a candidate for enzyme replacement the	nerapy?	
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



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:

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EOC ID:

Multiple Sclerosis-1 Medicare

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

Patient Name:	Prescriber Name:	
		Dhana
Member/Subscriber Number:	Fax: Office Contact:	Phone:
Date of Birth: Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lic ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	<i>i</i>):
*Please note that Elixir will process the request as writte		
Please note that Linkii will process the request as write	<u> </u>	o substitution.
Drug Name and Strength:	☐ Expedited/Urgent	
Drug Name and Strength.		
Directions / SIG:		
Please attach any pertinent medical history or information		approval. Please answer the
tollowing qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the medication that is being requested	l:	
☐ Avonex		
Betaseron		
Copaxone/Glatiramer		
Gilenya		
Tecfidera/Dimethyl Fumarate		
Q4. Please indicate the patient's diagnosis for the requeste	ed medication:	
Relapsing forms of multiple sclerosis (MS) (e.g., clin	ically isolated syndrome, relapsin	g-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:		



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 consul	tation 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



EOC ID:

Natpara-1 Medicare

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

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 writt	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Hypoparathyroidism	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Will the requested medication be used to control hypo	calcemia?	
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
Prescriber Signature		 Date



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:

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EOC ID:

Nerlynx-1 Medicare

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

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 writte	en, 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 st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 ca	ancer	
☐ 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-☐ None of the above	based regimens in the metastatic	setting
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	



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	n consultation with an oncologist?	
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Nexavar-1 Medicare

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

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 applicab	le):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may supportestions and sign.	t approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
Advanced renal cell carcinoma		
Locally recurrent or metastatic, progressive, differentia	ated thyroid carcinoma	
☐ Unresectable hepatocellular carcinoma	,	
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow:	
a in it and passessions assigned to a recomplete		
Q5. For DIFFERENTIATED THYROID CARCINOMA, is the	e disease refractory to radioacti	ve 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 beir	ng treated with carboplatin and p	aclitaxel?
	□ No	



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		



EOC ID:

Ninlaro-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	e.ie.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Elixir will process the r	equest as written, including drug name	e, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may s following questions and sign.	support approval. Please answer the
	-	
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, plea	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s 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	d in combination with lenalidomide (Revlin	nid) and dexamethasone?
☐ Yes	□No	,
Q6. Does the patient have a history of at le	east one prior therapy?	
☐ Yes	□No	
Q7. Is the patient 18 years of age or older	?	
☐ Yes	□ No	



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



EOC ID:

Northera-2 Medicare

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

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 na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform following	nation for this patient that mang questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the rec	quested medication:	
☐ Neurogenic orthostatic hypotension (NOH)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spo	ecify below:	
Q5. Is the patient symptomatic?		
☐ Yes	☐ No	
Q6. Is the patient's diagnosis caused by one of the fo		hat apply.)
☐ Primary autonomic failure (for example, Parkin	son's disease, multiple syste	em atrophy, pure autonomic failure)
Dopamine beta-hydroxylase deficiency	, ,	,
☐ Non-diabetic autonomic neuropathy		
☐ None of the above		



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



EOC ID:

Nubeqa-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 consul	tation with an oncologist or urolog	ist?
☐ Yes	□ No	
Prescriber Signature		Date



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:

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EOC ID:

Nucala-1 Medicare

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

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 applic	able):
*Please note that Elixir will process the request as writt	en, including drug name, wit	th no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may supplestions and sign.	ort approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 c hematologic secondary cause?	ondition lasted at least 6 mont	hs without an identifiable non-
☐ Yes	□ No	
Q6. Is the patient 6 years of age or older?		
☐ Yes	□ No	
Q7. Is the requested medication prescribed by or in consu	Itation with any of the following	g?



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	



EOC ID:

Nuedexta-1 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following gu	n for this patient that may support a	approval. Please answer the
9 4		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 consu	Itation with a neurologist?	
☐ Yes	□ No	
Q7. Does the patient have any of the following? (Please se	elect all that apply.)	
☐ History of prolonged QT interval, congenital long QT☐ Heart failure	syndrome or Torsades de pointe	98
☐ Complete AV block without an implanted pacemake☐ Concomitant use with quinidine, quinine, mefloquine	·	



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



EOC ID:

Nuplazid-1 Medicare

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

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 (i	f applicable):
*Please note that Elixir will process the request as writ	ten, including drug nan	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that may	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
O2 Diagon in diagon the metional diagnosis for the resume	to due o disotion.	
Q3. Please indicate the patient's diagnosis for the reques	<u></u>	
Parkinson's disease psychosis	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient experiencing hallucinations and/or delu	sions?	
Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
	□Na	
Yes	□ No	
Prescriber Signature		Date



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:

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EOC ID:

Octreotide-1 Medicare

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

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 a	applicable):
*Please note that Elixir will process the	request as written, including drug name	e, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical hist	ory or information for this patient that may solutions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosi	is for the requested medication:	
☐ Acromegaly		
☐ Metastatic carcinoid syndrome		
☐ Vasoactive intestinal peptide-secretin☐ Other	g tumor (VIPoma) with associated diarrhea	a
Q4. If the patient's diagnosis is OTHER	R, please specify below:	
Q5. For ACROMEGALY, has the patient select all that apply)?	had an inadequate response to or is ineligi	ible for any of the following (please
Surgery		
Radiation		
☐ Bromocriptine mesylate		
☐ None of the above		
	the options listed in the previous question, history of adverse event, patient is not a ca	



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



EOC ID:

Odomzo-1 Medicare

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

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 writ	ten, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following quantum process of the control of the cont	on for this patient that muuestions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted 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 radiati	on therapy	
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
Yes	☐ No	
Q7. Is the patient pregnant?		
☐ Yes		
□No		



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 poter	ntial
Prescriber Signature	Date



EOC ID:

Onureg-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D:1: / 010		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
<u> </u>	<u> </u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 mainten complete remission (CR) or complete remission with incominduction chemotherapy?	•	
☐ Yes	□ No	
Q6. Is the patient able to complete intensive curative thera	py?	
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□No	



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



EOC ID:

Opsumit-1 Medicare

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

Patient Name:	Prescriber Name:	
ratient Name.	Frescriber 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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		pproval. Please answer the
following que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Pulmonary arterial hypertension (PAH), World Health	□ 0# · · ·	
Organization group I	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify by	pelow:	
Q4. If the patient's diagnosis is OTTIEN, please specify t	Selow.	
Q5. Was the diagnosis confirmed by right heart catheteriza		the patient is unable to
undergo a right heart catheterization (e. g., patient is frail, e	elderly, etc.)?	
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
	<u> </u>	
Q7. Is the requested medication prescribed by or in consult	tation with a pulmonologist or card	diologist?
☐ Yes	□ No	



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: Preso		Prescriber Name:
Q8. Is the patient pregnant?)	
☐ Yes	☐ No	☐ Not applicable
Prescribe	er Signature	 Date



EOC ID:

Orilissa-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Moderate to severe pain associated with endometriosis	Other	
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Does the patient have any of the following (please selection of the patient have any of the following (please selection of the patient of the patient of the patient of the above		3



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



EOC ID:

Orkambi-1 Medicare

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

Patient Name:	Prescriber Name:	
		DI.
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	State Lic ID:
Group Number: Address:	NPI: Address:	State Lic ID:
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	annlicable):
*Please note that Elixir will process the		
- Trease note that Linkii will process the l	Expedited/Urge	·
Drug Name and Strength:	,	
Directions / SIG:		
Please attach any pertinent medical hist	ory or information for this patient that may following questions and sign.	support approval. Please answer the
	Tollowing questions and sign.	
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosi	is for the requested medication:	
_		
Cystic fibrosis (CF)	☐ Other	
Q4. If the patient's diagnosis is OTHER	R, please specify below:	
Q5. Does the patient have documented h test?	omozygous F508del mutation as confirm	ed by a FDA-approved CF mutation
☐ Yes	□No	
Q6. Is the medication prescribed by, or in center accredited by the Cystic Fibrosis F		scribing practitioner from a CF
☐ Yes	□ No	
<u> </u>		
Prescriber Signature		 Date



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:



EOC ID:

Osphena-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
2			
Please attach any pertinent medical history or information following que	for this patient that may support a	approval. Please answer the	
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 requeste	ed medication:		
☐ Moderate to severe dyspareunia due to vulvar and v	aginal atrophy associated with me	enopause	
 ☐ 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 sele	ect all that apply)?		
☐ Undiagnosed abnormal genital bleeding			
☐ Known or suspected estrogen-dependent neoplasia			
☐ Active deep vein thrombosis (DVT), pulmonary emb	olism (PE), or a history of these c	onditions	
☐ Active arterial thromboembolic disease (eg. stroke, r☐ Pregnancy	myocardial infarction) or a history	of these conditions	



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



EOC ID:

Oxandrolone-1 Medicare

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

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 writte	en, including drug name, with no	substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the	
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 requeste	ed medication:		
☐ Bone pain associated with osteoporosis			
☐ Protein catabolism associated with chronic corticostero	oid administration		
Adjunctive therapy to promote weight gain			
☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify I	pelow:		
Q5. FOR ADJUNCTIVE THERAPY TO PROMOTE WEIGH	HT GAIN: Is the requested medica	tion 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☐ None of the above	weight without definite pathophys	siologic reasons	



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	



EOC ID:

Panretin-1 Medicare

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

Prescriber Name:			
Fax:	Phone:		
Office Contact:			
NPI:	State Lic ID:		
Address:			
City, State ZIP:			
Specialty/facility name	(if applicable):		
en, including drug na	me, with no substitution.		
☐ Expedited/Urg	gent		
	y support approval. Please answer the		
☐ Continuing the	erapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
ed medication:			
☐ Other			
below:			
Q5. Do any of the following apply to this patient (please select all that apply)?			
☐ The requested medication is being used to treat cutaneous lesions			
Systemic anti-Kaposi's Sarcoma (KS) therapy is not indicated (e.g., patient does not have more than 10 new KS			
lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement)			
	Fax: Office Contact: NPI: Address: City, State ZIP: Specialty/facility name of the forthis patient that makes and sign. Continuing the tart date (MM/YY): ced medication: Other below: clect all that apply)? aneous lesions indicated (e.g., patient)		



EOC ID:

Panretin-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	
Q7. Is the requested medication being prescribed by or in consultation with an oncologist or HIV specialist?		
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Pegylated Interferon-1 Medicare

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

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 a	applicable):	
*Please note that Elixir will process the re	equest as written, including drug name	e, with no substitution.	
	☐ Expedited/Urger	nt	
Drug Name and Strength:			
D			
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 t	herapy?		
☐ Initial therapy	☐ Continuing thera	ру	
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 follow	ving (please select all that apply)?		
	mmune condition known to be exacerbate	ed by interferon	



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 genoty	pe below:		
Q8. For HEPATITIS C: Please provide the patient's initial RNA level and week of treatment:	HCV RNA level and, if continuing therapy, the current HCV		
Q9. For HEPATITIS C: Will the requested medication be u	sed in conjunction with Sovaldi?		
☐ Yes	□ No		
Q10. For HEPATITIS C: Is the patient treatment-naive or e	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		



EOC ID:

Pemazyre-1 Medicare

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

D. C. AM.	Daniel Harris		
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 writte	n, 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 a	pproval. Please answer the	
following que	stions and sign.		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the sta	art date (MM/YY)·		
azir di delitimidine inizia i, picaco pichac alcoa	art date (11111/1 1).		
Q3. Please indicate the patient's diagnosis for the requeste	d medication:		
☐ Cholangiocarcinoma, unresectable locally advanced of	or —		
metastatic	Other		
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Does the patient have confirmed fibroblast growth factor	or recentor 2 (ECEP2) fusion or ot	hor roarrangement as	
detected by a FDA-approved test?	or receptor 2 (FGFR2) rusion or or	nei rearrangement as	
, , , , , , , , , , , , , , , , , , , ,			
Yes	□ No		
Q6. Has the patient been previously treated?			
☐ Yes	□ No		
Q7. Is the patient 18 years of age or older?			
☐ Yes	□ No		



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 conshepatologist?	sultation with an oncologist, gastroenterologist, or		
☐ Yes	□ No		
Prescriber Signature	 Date		



EOC ID:

Piqray-1 Medicare

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

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 writte	en, 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 requeste	ed 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		



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 consul	tation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Pomalyst-1 Medicare

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

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 writte	en, including drug name, with n	o 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 requeste	ed 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 antiretr	oviral therapy (HAART)?	
Yes	□ No	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Q6. FOR MULTIPLE MYELOMA, please select all that app	ply to this patient:		
☐ The requested medication will be used in combination	on with dexamethasone in an adul	t patient	
The patient has received at least 2 prior therapies (in		·	
☐ The patient has demonstrated disease progression ☐ None of the above	on or within 60 days of completion	of the last therapy	



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 poter	ntial
Prescriber Signature	



EOC ID:

Promacta-1 Medicare

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

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	f applicable):
*Please note that Elixir will process the	request as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosi	s for the requested medication:	
Chronic idiopathic thrombocytopenic	ourpura (ITP)	
☐ Chronic hepatitis C infection associate		
☐ Severe aplastic anemia		
☐ Other		
Q4. If the patient's diagnosis is OTHER	R, please specify below:	
Q5. For APLASTIC ANEMIA, please sele	ct any of the following that apply to the pa	atient:
☐ The patient had an insufficient resp	onse to immunosuppressive therapy	
1	sed in combination with standard immun	osuppressive therapy
☐ None of the above		
Prescriber Signature		Date



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:
This telecopy transmission contains confidential information belonging to the sender the	,



EOC ID:

Pulmonary Fibrosis-1 Medicare

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

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 nam	ne (if applicable):
*Please note that Elixir will process the request as writte	en, including drug i	name, with no substitution.
	☐ Expedited/	Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following gu	n for this patient that estions and sign.	may support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing	therapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate which medication this request is for:		
☐ Esbriet	Ofev	
Q4. Please indicate the patient's diagnosis for the requeste	ed 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 consu	Itation with a pulmon	ologist?
☐ Yes	☐ No	



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



EOC ID:

Qinlock-1 Medicare

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

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 reque	st as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Disco attack any next next medical biotem, or	information for this potions that made	vicinia and a managed. Disease a negues the
Please attach any pertinent medical history or for	information for this patient that ma bllowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therap	by?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please pro	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for t	he requested medication:	
<u> </u>	<u></u>	
Gastrointestinal stromal tumor (GIST), ad	vanced Other	
Q4. If the patient's diagnosis is OTHER, plea	se specify below:	
Q4. If the patient's diagnosis is OTHER, plea	se specify below:	
Q4. If the patient's diagnosis is OTHER, plea Q5. Has the patient received prior treatment wit		uding imatinib (Gleevec)?
		uding imatinib (Gleevec)?
Q5. Has the patient received prior treatment wit Yes Q6. If the patient has NOT tried 3 or more kir	h 3 or more kinase inhibitors, inclu No nase inhibitors, including imatinib (Gleevec), is there a reason why these
Q5. Has the patient received prior treatment wit	h 3 or more kinase inhibitors, inclu No nase inhibitors, including imatinib (Gleevec), is there a reason why these
Q5. Has the patient received prior treatment wit Yes Q6. If the patient has NOT tried 3 or more kir	h 3 or more kinase inhibitors, inclu No nase inhibitors, including imatinib (Gleevec), is there a reason why these



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



EOC ID:

Regranex-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	T Hone.
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 w	ritten, including drug na	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	ation for this patient that mag	y support approval. Please answer the
	 	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the	ne start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	uested medication below:	
☐ Lower extremity diabetic neuropathic ulcer	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spec	cify below:	
Q5. Does the ulcer extend into the subcutaneous tissu	e or beyond and have an a	dequate 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 si	te of application?	
Yes	☐ No	



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



EOC ID:

Repatha-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D: 1: 1010		
Directions / SIG:		
Please attach any pertinent medical history or information		pproval. Please answer the
following que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Primary hyperlipidemia (hypercholesterolemia) includir	ng heterozygous familial hypercho	lesterolemia (HeFH)
☐ Homozygous familial hypercholesterolemia		
Required prophylaxis of myocardial infarction, stroke, o	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 CARDIOVASC	ULAR 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		



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 at ☐ None of the above	herosclerotic region
Q6. Is the patient 13 years of age or older?	
☐ Yes	□ No
Prescriber Signature	



EOC ID:

Retevmo-1 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:	0	
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 writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
	. Constitution of the state of	- I Division di	
Please attach any pertinent medical history or information following qu	i for this patient that may support a estions and sign.	pproval. Please answer the	
	-		
Q1. Is this request for initial or continuing therapy?			
│	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Medullary thyroid cancer (MTC), advanced or metas	static, 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:			
Q4. If the patient's diagnosis is OTTLIX, please specify	Delow.		
Q5. Please select all that apply to the patient:			
☐ The patient requires systemic therapy (such as the i	equested medication)		
☐ The patient is refractory to radioactive iodine, if appropriate			
☐ None of the above			
Q6. Is the requested medication prescribed by or in consul	tation with an oncologist?		
☐ Yes	□ No		



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



EOC ID:

Revlimid-1 Medicare

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

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 r	equest as written, including drug name	e, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing to	therapy?	
☐ Initial therapy	☐ Continuing thera	ару
Q2. For CONTINUING THERAPY, plea	se 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 inc In combination with dexamethasone Following autologous hematopoietic None of the above	e stem cell transplantation	
Q6. For TRANSFUSION-DEPENDENT ANEMIA DUE TO MDS, is the condition associated with a deletion 5q		



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:	
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 poter	ntial	
Prescriber Signature	 Date	



EOC ID:

Rezurock-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	ifor this patient that may support a estions and sign.	pproval. Please answer the
-		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Chronic graft-vs-host disease in adult and pediatric patients	Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Has the patient failed at least 2 prior lines of systemic	therapy?	
☐ Yes	□ No	
Q6. If the patient has NOT tried at least 2 prior lines of s cannot be used (i.e., contraindication, history of adverse		why these medications



EOC ID:

Rezurock-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 12 years of age or older?		
☐ Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Rozlytrek-1 Medicare

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

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 applical	ole):
*Please note that Elixir will process the request as writt	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	n for this patient that may suppor lestions and sign.	t approval. Please answer the
Q1. Is this request for initial or continuing therapy?	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 the surgious The patient's tumors are metastatic or where surgious The patient's tumors have either progressed followis None of the above	al resection is likely to result in s	•
Q6. Is the patient 12 years of age or older?		
☐ Yes	□ No	



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 consu	ultation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Rubraca-1 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with r	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Deleterious BRCA mutation (germline and/or somati	c)-associated metastatic castration	on-resistant prostate cancer
☐ Epithelial ovarian, fallopian tube, or primary peritone		•
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR Fapply to the patient:	PRIMARY PERITONEAL CANCE	R, please select all that
☐ The patient has deleterious BRCA mutation (germlir	e 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 maintenal	nce treatment	
☐ The patient is in complete or partial response to plat	inum-based chemotherapy	
☐ None of the above		



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	



EOC ID:

Rydapt-1 Medicare

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

	T	
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 app	plicable):
*Please note that Elixir will process the request as writte	en, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may su estions and sign.	pport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 sele	ect all that apply to the patie	ent:
☐ 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?		



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



EOC ID:

Samsca-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 resisted correction with fluid restriction?	less with marked hyponatremia tha	at is symptomatic and has
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Does the patient have any of the following (please sele	ect all that apply)?	



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



EOC ID:

Signifor-1 Medicare

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

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 (i	f applicable):
*Please note that Elixir will process the I	request as written, including drug nam	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is the request for initial or continuing t	herany?	
	_	**************************************
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, plea	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosi	s 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 re	sponse to or is not a candidate for surge	ery?
☐ Yes	□ No	
Q6. FOR RENEWAL: Is there documental levels or improvement in signs or symptor		n 24-hour urinary free cortisol (UFC)
☐ Yes	□ No	
Prescriber Signature		Date



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:
This telepopy transmission contains confidential information belonging to the condex t	est is legally privileged. This information is intended only for the us



EOC ID:

Sildenafil-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicab	le):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
2.100.101.67 6.10.		
Please attach any pertinent medical history or information following qu	n for this patient that may support estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Pulmonary arterial hypertension (WHO Group I)	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
a in it to patient a diagnosis to a might produce opeout	20.011.	
Q5. Was the patient's diagnosis confirmed by right heart cunable to undergo a right heart catheterization (e.g., patier		ardiogram if the patient is
☐ 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 (include	les intermittent use)?	



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 Signatur	re Date	



EOC ID:

Somatuline Depot-1 Medicare

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

Deffect Names	December Name	
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	e):
*Please note that Elixir will process the request as writt	ten, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Billiod and 7 cite.		
Please attach any pertinent medical history or informatio following qu	n for this patient that may support a lestions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Acromegaly		
☐ Carcinoid syndrome		
☐ Gastroenteropancreatic neuroendocrine tumors (GEP	-NETs), Unresectable, well or mod	derately 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	g 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	1,	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	



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 Nam	e:
		·	
	Prescriber Signature		Date



EOC ID:

Somavert-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Birodions / Gro.		
Please attach any pertinent medical history or information following que	for this patient that may support a	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Acromegaly	Other	
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Has the patient had an inadequate response to or is in	eligible for surgery or radiation the	erapy?
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Was the requested medication prescribed by or in con-	sultation with an endocrinologist?	
☐ Yes	□No	



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



EOC ID:

Sprycel-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
	. for this mations that many assume as	manayal Diagga anguyan tha
Please attach any pertinent medical history or information following qu	estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the star	t date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication: *	
☐ Philadelphia chromosome-positive acute lymphoblastic	c leukemia (Ph+ ALL)	
☐ Philadelphia chromosome-positive chronic myelogeno	,	
☐ Other	, ,	
Q4. If the patient's diagnosis is OTHER, please specify be	low	
Q4. If the patient's diagnosis is Official, please specify be	IOW.	
OF FOR ACUITE LYMPHODI ACTIC LEUKEMIA Places of	leat one of the following that apply	, to the notions
Q5. For ACUTE LYMPHOBLASTIC LEUKEMIA, please se		to the patient:
Patient had resistance or intolerance to prior therapy		ithab.a.a.ath.a.a.a.
☐ Disease is newly diagnosed and the requested med ☐ None of the above	ication will be used in combination	with chemotherapy
Q6. For CHRONIC MYELOGENOUS LEUKEMIA, please s	select any of the following that app	oly to the patient:
☐ Disease is newly diagnosed in the chronic phase		
Disease is chronic, accelerated, or myeloid or lymph	noid blast phase with resistance or	intolerance to prior therapy
☐ None of the above		



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 consu	ultation with an oncologist?	
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Stelara-3 Medicare

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

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 a	applicable):
*Please note that Elixir will process the request as writte	en, including drug name	e, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		support approval. Please answer the
tollowing que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 apply)?	contraindication to any o	f the following (please select all that
☐ Enbrel ☐ Humira		☐ None of the above
Q6. If the patient has NOT tried any of the medications I medications cannot be used (i.e., contraindication, histo		-



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



EOC ID:

Stivarga-1 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
O2 Places indicate the nationals diagnosis for the request	ad madiantian balaus	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication below.	
Colorectal cancer, metastatic	d	
☐ Gastrointestinal stromal tumor (GIST), locally advance ☐ Liver carcinoma	a, unresectable of metastatic	
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 pr that apply)?	eviously treated with any of the fo	llowing (please select all
☐ Fluoropyrimidine-, oxaliplatin-, and irinotecan-contai	ning chemotherapy	
☐ Anti-VEGF therapy		
☐ Anti-EGFR therapy		



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 (Si	utent)		
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 previous	ously 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		



EOC ID:

Sunosi-1 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with i	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:	,	
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support estions and sign.	approval. Please answer the
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 requeste	ed medication:	
☐ Obstructive sleep apnea (OSA)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
OF Doos the potient have exceeding douting drawnings		
Q5. Does the patient have excessive daytime drowsiness?	<u></u>	
Yes	□ No	
Q6. Does the patient have a trial of or contraindication to a	ny of the following? (Please sele	ct all that apply.)
Armodafinil Modafinil	□Nor	e of the above
		5 5. 110 aboro
Q7. If the patient has NOT tried any of the medications I medications cannot be used (i.e., contraindication, histo		there a reason why these



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 search Concomitant use of a monoamine oxidase inhibitor (Use within 14 days of discontinuing a monoamine ox None of the above	(MAOI)
Prescriber Signature	



EOC ID:

Sutent-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support apestions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication: *	
☐ Gastrointestinal stromal tumor		
☐ Pancreatic neuroendocrine tumors, unresectable locall	y 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 imatinib (Gleevec)?	ne patient had disease progression	on or an intolerance to
☐ Yes	□ No	
Q6. If the patient has NOT tried imatinib (Gleevec), is the contraindication, history of adverse event, etc.)?	ere a reason why this medication c	annot be used (i.e.,
Q7. For RENAL CELL CARCINOMA, please select all that	apply to the patient:	



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 t for recurrence ☐ None of the above	herapy following nephrectomy in a patient who is at high risk
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Prescriber Signature	



EOC ID:

Symdeko-1 Medicare

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

Deticut Name	Dungarihan Namar	
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 writt	en, including drug nam	e, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may lestions and sign.	support approval. Please answer the
Tollowing qu	iestions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	anv
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Cystic fibrosis (CF)	Other	
Gystic fibrosis (or)		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select if any of the following apply to this patie	nt:	
☐ The patient is homozygous for the F508del mutation		
☐ Patient has at least one mutation in the cystic fibro		uctance regulator (CFTR) gene that
is responsive to tezacaftor/ivacaftor verified by a FDA-cle		, , , , , , , , , , , , , , , , , , , ,
☐ None of the above		
Q6. Is the patient 6 years of age or older?		
	□ N.	
Yes	☐ No	
Q7. Is the requested medication being prescribed by or in	consultation with a pulm	onologist or a prescribing
practitioner from a CF center accredited by the Cystic Fibr		- · · · · ·



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 Signatur	re Date	



EOC ID:

Symlin-2 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	ifor this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 sele	ect all that apply)?	
☐ Confirmed diagnosis of gastroparesis		
☐ Hypoglycemia unawareness		
☐ None of the above		



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	



EOC ID:

Tabrecta-1 Medicare

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

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 app	plicable):
*Please note that Elixir will process the request as writt	en, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following gu	n for this patient that may su estions and sign.	pport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	/
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 lea	ds to mesenchymal-epitheli	al 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 consu	itation with an oncologist?	
☐ Yes	☐ No	



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



EOC ID:

Tafinlar-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Anaplastic thyroid carcinoma, locally advanced or met	astatic	
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 se	elect 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	ct all that apply to the patient:	
☐ Patient has BRAF V600E mutation		



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 ☐ Patient was previously treated as monotherapy ☐ None of the above	on with trametinib (Mekinist)
Q7. For MELANOMA, does the patient have a BRAF V600	DE 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 consul	Itation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Tagrisso-1 Medicare

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

Date of Birth: Group Number: Address: City, State ZIP: Primary Phone: *Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent Drug Name and Strength:	Patient Name:	Prescriber Name:	
Group Number: Address: Address: City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Member/Subscriber Number:	Fax:	Phone:
Address: City, State ZIP: City, State ZIP: Specially/facility name (if applicable): **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Date of Birth:	Office Contact:	
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	Group Number:	NPI:	State Lic ID:
Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution.	Address:	Address:	
Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	City, State ZIP:	City, State ZIP:	
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	Primary Phone:	Specialty/facility name (if applicable)	:
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	*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
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		☐ Expedited/Urgent	
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	Drug Name and Strength:		
Q1. Is this request for initial or continuing therapy? Initial therapy	Directions / SIG:		
□ 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?			pproval. Please answer the
□ 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?			
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 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	Q1. Is this request for initial or continuing therapy?		
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	☐ Initial therapy	☐ Continuing therapy	
□ 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	Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
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	Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
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?	☐ Non-small cell lung cancer (NSCLC), metastatic	Other	
☐ 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?	Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
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?	Q5. Please select all that apply to the patient:		
☐ 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?			
☐ 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?	☐ The requested medication is being used as first-line 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?	☐ There is confirmed presence of T790M EGFR mutation		
☐ None of the above Q6. Is the patient 18 years of age or older?			
		proved test	
	Q6. Is the patient 18 years of age or older?		
		□No	



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 consu	ltation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Takhzyro-1 Medicare

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

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 applical	ole):
*Please note that Elixir will process the request as writt	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may supportestions and sign.	rt approval. Please answer the
<u> </u>	<u> </u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the star	t date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Hereditary angioedema (HAE)	Other	
Q4. If the patient's diagnosis is OTHER, please specify be	low:	
Q5. Will the requested medication be used in the prevention	on of angioedema attacks?	
☐ Yes	□ No	
Q6. Does the patient have a trial of or contraindication to F	Firazyr?	
☐ Yes	□ No	
Q7. If the patient has NOT tried Firazyr, is there a reason history of adverse event, etc.)?	on why this medication cannot be	e used (i.e., contraindication,
Q8. Is the patient 12 years of age or older?		



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 allergist?	consultation with a hematologist, immunologist, or
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Talzenna-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact: NPI:	State Lic ID:
Group Number: Address:	Address:	State Lic ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte		
· · · · · · · · · · · · · · · · · · ·	☐ Expedited/Urgent	
Drug Name and Strength:	1 9.	
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
_ ·	Other	
Breast cancer, locally advanced or metastatic	Ottlei	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have a deleterious or suspected dele mutated (gBRCAm)?	terious germline breast cancer sus	sceptibility gene (BRCA)-
☐ Yes	□ No	
Q6. Is the patient's disease human epidermal growth facto	r 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 consul	tation with an oncologist?	



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 Signatu	re Date	



EOC ID:

Targretin Gel-1 Medicare

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

Patient Name:	Prescriber Name:	
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 appl	licable):
*Please note that Elixir will process the request as written	en, including drug name, w	vith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following gu	າ for this patient that may sup estions and sign.	port approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please indicate the s	start date (MM/YY):	
	,	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Primary cutaneous T-cell lymphoma (CTCL Stage		
1A/1B)	Other	
Q4. If the patient's diagnosis is OTHER, please specify	holow	
44. If the patient's diagnosis is OTTICIX, please specify	Delow.	
Q5. Has the patient had an inadequate response, intolerar (e.g., corticosteroids) indicated for cutaneous manifestatio		least one prior systemic therapy
│ │ │ Yes	☐ No	
Q6. If the patient has NOT tried one prior systemic thera	, , ,	here a reason why it cannot be
used (i.e., contraindication, history of adverse event, etc	C.)?	
Q7. Is the requested medication being prescribed by or in	consultation with an oncolog	ist or dermatologist?
☐ Yes	☐ No	



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:	Prescribe	Name:
	•	
Prescriber Signature		Date



EOC ID:

Tasigna-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Filone.
Group Number:	NPI:	State Lic ID:
Address:	Address:	Clare Lie 15.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applic	cable):
*Please note that Elixir will process the request as writte	en, including drug name, wi	ith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:	· · · ·	
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may suppestions and sign.	port approval. Please answer the
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 request	ed medication: *	
☐ Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in chronic phase		
☐ Philadelphia chromosome-positive chronic myelogeno☐ Other	us leukemia (Ph+ CML) in ac	celerated phase
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select any of the following that applies to the p	atient:	
☐ 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☐ None of the above	kinase inhibitor therapy	
Q6. Is the requested medication prescribed by or in consu	Itation with an oncologist?	
☐ Yes	□No	



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 sele	ect all that apply)?
☐ Long QT syndrome	
☐ Uncorrected hypokalemia	
☐ Uncorrected hypomagnesemia	
☐ None of the above	
Prescriber Signature	Date



EOC ID:

Tazverik-1 Medicare

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

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 reque	est as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history of	r information for this patient that ma following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing thera	py?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, please p	rovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	the requested medication:	
☐ Epithelioid sarcoma, metastatic or locally a	•	
Follicular lymphoma, relapsed or refractory		
☐ Other		
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. For EPITHELIOID SARCOMA, is the patie	nt eligible for complete resection?	
☐ Yes	□ No	
Q6. For FOLLICULAR LYMPHOMA, please se	lect 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 alternation	ve treatment options	
☐ None of the above		
· · · · · · · · · · · · · · · · · · ·		



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 consul	tation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Tegsedi-2 Medicare

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

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 applied	cable):
*Please note that Elixir will process the request as writte	en, including drug name, w	ith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may suppestions and sign.	port approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Polyneuropathy of hereditary transthyretin-mediated amyloidosis	Other	
Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q6. Does the patient have any of the following (please sele	ect all that apply)?	
☐ Platelet count less than 100,000 per microliter		
☐ Urinary protein to creatinine ratio (UPCR) of 1000 m	g/g or higher	
☐ None of the above		
Prescriber Signature		Date



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:



EOC ID:

Tepmetko-1 Medicare

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

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 app	licable):
*Please note that Elixir will process the request as writte	en, including drug name, v	vith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may sup estions and sign.	port approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 transiti	on (MET) exon 14 skipping a	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 oncolog	ist?



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 Signatur	re Date	



EOC ID:

Teriparatide-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Osteoporosis due to associated sustained systemic glu	ucocorticoid therapy	
☐ Postmenopausal osteoporosis		
☐ Primary or hypogonadal osteoporosis in a male patient	:	
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify I	pelow:	
Q5. Does the patient have a previous trial and failure, cont	raindication, or intolerance to a bis	sphosphonate?
☐Yes	□No	
Q6. For POSTMENOPAUSAL OSTEOPOROSIS, does the	e patient have a history of or contra	aindication to Tymlos?
☐ Yes	. □ No	•
Q7. If the patient has NOT tried any of the medication(s) list medications cannot be used (i.e., contraindication, history		ere a reason why these



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:
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 trea	atment with the requested medication?
☐Yes	□ No
Prescriber Signature	Date



EOC ID:

Tetrabenazine-1 Medicare

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

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 writt	en, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that muestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 sel	lect 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 d	liscontinuing reserpine	•
☐ None of the above		
Prescriber Signature		Date



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:



EOC ID:

Thalomid-2 Medicare

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

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 reques	st as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or fo	information for this patient that ma Illowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therap	w2	
	<u></u>	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please pro	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	ne requested medication:	
☐ Multiple myeloma, newly diagnosed		
☐ Erythema nodosum leprosum (ENL)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, pleas	se specify below:	
a and parieties alaginosis is a a. i, prosi-		
Q5. Is the requested medication being prescribe	ed by or in consultation with an on	cologist or infectious disease
specialist?	,	G I
☐ Yes	□No	
Q6. Is the patient pregnant?		
☐ Yes		
□ No		
☐ Not applicable - patient is not of child-bearing	g potential	
	· .	



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



EOC ID:

Tibsovo-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 dehydrogen ☐ The patient is 75 years of age or older ☐ The patient has comorbidities that preclude use of ir ☐ None of the above 	·	FDA-approved test
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	



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 consu	Itation with an oncologist or hematologist?
☐ Yes ☐ No	
Prescriber Signature	Date



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 w	ritten, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	tion for this patient that ma	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide th	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requi	ested medication:	
☐ Wilson's disease	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spec	ify below:	
Q5. Does the patient have an intolerance to penicillami	ne?	
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Trikafta-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed 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 (CFTR) gene verified by an FDA-cleared CF mutation test		ne conductance regulator
☐ Yes	□ No	
Q6. Is the patient 12 years of age or older?		
☐ Yes	□ No	
Q7. Is the requested medication prescribed by or in consu a CF center accredited by the Cystic Fibrosis Foundation?		rescribing practitioner from
☐ Yes	□No	



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



EOC ID:

Truseltiq-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Cholangiocarcinoma, unresectable locally advanced metastatic	or Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have a fibroblast growth factor recept an FDA-approved test?	tor 2 (FGFR2) fusion or other rear	rangement as detected by
☐ Yes	□ No	
Q6. Has the patient been previously treated?		
☐ Yes	□ No	



EOC ID:

Truseltiq-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 being prescribed by or in hepatologist?	consultation with an oncologist, gastroenterologist, or
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Tukysa-1 Medicare

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

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 ap	plicable):
*Please note that Elixir will process the request as writte	en, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may suestions and sign.	ipport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	y
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Breast cancer, advanced unresectable or metastatic (including brain metastases)	Other	
Q4. If the patient's diagnosis is OTHER, please specify t	pelow:	
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-HER	22-hased regimens in the n	netastatic setting
☐ The requested medication is being used in combinat		
☐ None of the above	ion with tractazamas (Fron	sopini, and superindenie (stoicad)
Q6. Is the patient 18 years of age or older?		
	□No	
Yes	☐ No	
Q7. Is the requested medication prescribed by or in consul-	tation with an oncologist?	



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 Signatu	re Date	



EOC ID:

Turalio-1 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D: 1: (010		
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 request	ed 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 patier	nt:	
☐ The patient is symptomatic		
☐ 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 consu	Itation with an oncologist?	
Yes	☐ No	



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	



EOC ID:

Tymlos-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support apestions and sign.	oproval. Please answer the
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 requeste	ed 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 mu	ultiple 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?		



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



EOC ID:

Ukoniq-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
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 requeste	ed 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 r	eceived at least one prior anti-CD2	20-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.)?		



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



EOC ID:

Uptravi-3 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
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 writte	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / GIG.		
Please attach any pertinent medical history or information following que	for this patient that may support a	pproval. Please answer the
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 requeste	ed medication:	
☐ Pulmonary arterial hypertension (PAH), WHO Group I ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify I	oelow.	
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 conc	omitantly with strong CYP2C8 inh	ibitors (e.g.,



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



EOC ID:

Venclexta-1 Medicare

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

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 applicab	le):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
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?		



EOC ID:

Venclexta-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 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	



EOC ID:

Verquvo-3 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
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 requeste	ed 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	n less than 45%?	
☐ Yes	☐ No	
Q6. Has the patient had a previous hospitalization for hear treatment for HF within 3 months?	t failure (HF) within 6 months or o	utpatient IV diuretic
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		



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:	
☐ 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 concomistimulators?	tantly with other soluble guanylate cyclase (sGC)	
☐Yes	□ No	
Prescriber Signature		



EOC ID:

Verzenio-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Discretions / Olo		
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 st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Breast cancer, advanced or metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
Q5. Please select all that apply to the patient:		
☐ The patient's disease is hormone receptor (HR)-pos	itive	
☐ The patient's disease is human epidermal growth fac	ctor receptor 2 (HER2)-negative	
The requested medication is being used in combinate following and exting the reput	tion with fulvestrant for the treatme	ent of disease progression
following endocrine therapy The requested medication is being used as monother	arany for the treatment of disease	progression following
endocrine therapy	rapy for the treatment of disease	progression following
☐ The requested medication is being used as initial en	docrine-based treatment in combi	nation with an aromatase
inhibitor		
☐ The patient has received at least one prior chemothe	erapy regimen of Ibrance or Kisqa	li
☐ None of the above		



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:
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 contraindica	tion 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 medications cannot be used (i.e., contraindication, histogram)	listed in the previous question, is there a reason why these ory 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



EOC ID:

Vitrakvi-1 Medicare

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

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 re	quest as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Directions / Gre.		
Please attach any pertinent medical histor	y or information for this patient that ma following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing th	nerapy?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, pleas	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Solid tumors	☐ Other	
Solid turnors		
Q4. If the patient's diagnosis is OTHER,	please specify below:	
Q5. Please select all that apply to this patie	nt:	
	r surgically unresectable	
ine patient's disease is metastatic o		e fusion-positive
☐ The patient's disease is metastatic of ☐ The patient's disease is neurotrophic	receptor tyrosine kinase (itritit) gen	
The patient's disease is neurotrophic	ative treatments or has progressed fol	lowing treatment
☐ The patient's disease is neurotrophic☐ The patient has unsatisfactory altern☐ None of the above	ative treatments or has progressed fol	
☐ The patient's disease is neurotrophic☐ The patient has unsatisfactory altern	ative treatments or has progressed fol	



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



EOC ID:

Vizimpro-1 Medicare

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

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 na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform following	nation for this patient that mang questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	orony.
		ыару
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	uested 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 grown substitution mutations as detected by a FDA-approve		xon 19 deletion or exon 21 L858R
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by or in c	onsultation with an oncologi	st?
☐ Yes	☐ No	
	<u> </u>	



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:	
Prescriber Signature	Date	



EOC ID:

Voriconazole-2 Medicare

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

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	e):
*Please note that Elixir will process the request as writte	en, including drug name, with I	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
	. J P	
Q3. Please indicate the patient's diagnosis for the requested	ed medication:	
☐ Invasive aspergillosis		
☐ Candidemia		
☐ Esophageal candidiasis		
☐ Invasive candidiasis of the skin and infections in abdor		ounas
☐ Serious fungal infections due to Scedosporium apiosp ☐ Other	ermum 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 consu	Itation with an infectious disease	specialist?
☐ Yes	□ No	·



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 ho dose forms)	ospital setting? (NOTE: B vs D questions only apply to the IV
☐ Yes	□ No
Q8. Is the medication being given via an infusion pump? (N	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



EOC ID:

Votrient-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
<u> </u>	<u> </u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. What is the patient's diagnosis for the requested medi-	cation?	
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 receive	ed at least one prior chemotherapy	y?
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Is the requested medication prescribed by or in consul	tation with an oncologist?	
☐ Yes	□ No	



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



EOC ID:

Vyndamax-1 Medicare

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

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 w	ritten, including drug na	ame, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	tion for this patient that m questions and sign.	ay support approval. Please answer the
Od to this year and for initial or continuing the year?		
Q1. Is this request for initial or continuing therapy?	_	
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide th	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	ested medication:	
☐ Transthyretin related familial amyloid cardiomyop (wild type or hereditary)	athy	
Q4. If the patient's diagnosis is OTHER, please spec	cify below:	
Q5. Is the patient 18 years of age or older?		
☐Yes	☐ No	
Q6. Is the requested medication prescribed by or in cor	nsultation with a cardiolog	jist?
☐Yes	☐ No	
Prescriber Signature		 Date



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:
This telecopy transmission contains confidential information belonging to the sender th	nat is legally privileged. This information is intended only for the use of the individual or



EOC ID:

Welireg-1 Medicare

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

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 writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		oproval. Please answer the
following que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Von Hippel-Lindau (VHL) disease	Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Does the patient require therapy for any of the followin	g conditions that do not require im	mediate surgery?
☐ Renal cell carcinoma (RCC)		
☐ Central nervous system (CNS) hemangioblastomas		
☐ Pancreatic neuroendocrine tumors (pNET)		
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
, , ,		



EOC ID:

Welireg-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	
Q7. Is the patient pregnant?		
☐ Yes		
□No		
☐ Not applicable - the patient is not of child-bearing poter	ntial	
Prescriber Signature		Date



EOC ID:

Xalkori-1 Medicare

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

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)	i:
*Please note that Elixir will process the request as writte	en, 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 requeste	ed 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 consu	ultation with, an oncologist?	
☐ Yes	□ No	



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



EOC ID:

Xeljanz-4 Medicare

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

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 applical	ole):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	ifor this patient that may supporestions and sign.	rt approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed 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	polow:	
Q4. If the patient's diagnosis is OTTIEN, please specify	Delow.	
Q5. Has the patient had failure, contraindication, or intolera	ance to any of the following? (pl	ease select all that apply):
☐ Enbrel (etanercept) ☐ Humira (ada	ılimumab) 🗌 No	one 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 infe	ction prior to initiation of treatm	ent?



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



EOC ID:

Xgeva-2 Medicare

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

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 appl	icable):
*Please note that Elixir will process the request as write	ten, including drug name, w	rith no substitution.
	□ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this natient that may sun	nort annroyal Please answer the
	uestions and sign.	port approvali i rodoc dilonor tilo
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 request	ted 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	helow:	
44. If the patient's diagnosis is OTTLEN, please specify	below.	
OF FOR CLANIT OF ILL TUMOR OF THE DONE in the most		
Q5. For GIANT CELL TUMOR OF THE BONE, is the pati result in severe morbidity?	ent's disease unresectable or	surgical resection is likely to
	□ N.	
Yes	□ No	
Q6. For HYPERCALCEMIA OF MALIGNANCY, is the pat	ient's disease refractory to bis	sphosphonate therapy?
☐Yes		
□ No		
I .		



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 bisphosphona	tes	
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 tha	n 8.0 mg/dL)?	
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Xolair-2 Medicare

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

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 applicab	ole):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following gu	n for this patient that may suppor estions and sign.	t approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Chronic idiopathic urticaria		
☐ Moderate to severe persistent asthma		
□ Nasal polyps		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow	
Q4. If the patient's diagnosis is OTTEN, please specify	below.	
Q5. For URTICARIA, does the patient remain symptomatic	c despite H1 antihistamine thera	py?
☐ Yes		
□ No		
☐ Not applicable - the patient has not tried H1 antihistam	ine therapy	
Q6. If the patient has NOT tried H1 antihistamine therap	by, is there a reason why this me	edication cannot be used (i.e.,
contraindication, history of adverse event, etc.)?		



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 inadequ	uate response to nasal corticosteroids?	
☐ Yes	□ No	
Q9. If the patient has NOT tried nasal corticosteroids, is contraindication, history of adverse event, etc.)?	there a reason why these medications cannot be used (i.e.,	
Q10. Is the patient 6 years of age or older?		
☐ Yes	□ No	
Q11. Is the requested medication prescribed by or in const otolaryngologist, or pulmonologist?	ultation with an allergist, dermatologist, immunologist,	
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Xospata-2 Medicare

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

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 wri	itten, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati	ion for this patient that ma questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	sted 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 tyl	rosine kinase 3 (FLT3) m	utation as detected by an FDA-
approved test?		
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
O7 to the requested medication prescribed by as in according	coultation with an ancalar	viet er hemetelegiet?
Q7. Is the requested medication prescribed by, or in con		gist of Hematologist?
Yes	☐ No	



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



EOC ID:

Xpovio-1 Medicare

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

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 writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Diffuse large B-cell lymphoma, relapsed or refractory (mphoma)
☐ 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 medica	tion be used in combination with d	examethasone?
☐ Yes	□ No	
Q7. For MULTIPLE MYELOMA, has the patient received a	at least 4 prior therapies?	
☐ Yes	☐ No	



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:
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 medications cannot be used (i.e., contraindication, history	ed in the previous question(s), is there a reason why these 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 cons	ultation with, an oncologist or hematologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Xtandi-1 Medicare

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

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 red	quest as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that ma following questions and sign.	ay support approval. Please answer the
	<u> </u>	
Q1. Is this request for initial or continuing the	erany?	
_		arany.
☐ Initial therapy	Continuing the	етару
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis f	or the requested medication:	
☐ Prostate cancer (castration-resistant)		
☐ Prostate cancer (metastatic, castration-s	sensitive)	
☐ Other		
Q4. If the patient's diagnosis is OTHER, բ	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 oncolo	gist or urologist?
Yes	□ No	
Prescriber Signature		Date



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:



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 (it	f applicable):
*Please note that Elixir will process the re-	quest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	y or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing th	erapy?	
☐ Initial therapy	☐ Continuing the	тару
Q2. For CONTINUING THERAPY, please	e 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



EOC ID:

Xyrem-1 Medicare

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

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 applic	cable):
*Please note that Elixir will process the request as writte	en, including drug name, wi	th no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Discount of the state of the st	for all to real real real real real real real real	
Please attach any pertinent medical history or information following qu	i for this patient that may supp estions and sign.	ort approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
	, ,	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Narcolepsy with cataplexy	ou moureanom	
☐ Narcolepsy with excessive daytime drowsiness		
Other		
_		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. FOR NARCOLEPSY WITH EXCESSIVE DAYTIME D	ROWSINESS: Does the patie	nt have a trial of or
contraindication to any of the following? (Please select all	that apply)	
☐ Modafinil ☐ Armodafinil	1	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?		
· · · · · · · · · · · · · · · · · · ·		



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 se	lect all that apply)
☐ Concomitant treatment with sedative hypnotic agents	S
Succinic semialdehyde dehydrogenase deficiency	
☐ None of the above	
Prescriber Signature	



EOC ID:

Xywav-1 Medicare

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

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 ap	pplicable):
*Please note that Elixir will process the request as writte	en, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this nationt that may s	innort approval. Please answer the
	estions and sign.	apport approval. I lease unswer the
Q1. Is this request for initial or continuing therapy?	_	
☐ Initial therapy	☐ Continuing therap	у
Q2. For CONTINUING THERAPY, please provide the si	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Narcolepsy with cataplexy		
☐ Narcolepsy with excessive daytime drowsiness		
☐ Other		
O4 If the metional discussion of OTUED places are sife.	- ala	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
	20140111500 5 #	
Q5. FOR NARCOLEPSY WITH EXCESSIVE DAYTIME DI contraindication to any of the following? (Please select all to the following)	•	atient have a trial of or
☐ Modafinil ☐ Armodafinil	Γ	None of the above
	L	
Q6. If the patient has NOT tried modafinil or armodafinil	is there a reason why the	se medications cannot be used
(i.e., contraindication, history of adverse event, etc.)?		
Q7. Is the patient 7 years of age or older?		



EOC ID:

Xywav-1 Medicare

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Patient Name:	Prescriber Name:
☐ Yes	□ No
Q8. Does the patient have any of the following? (Please sel	
 ☐ Concomitant treatment with sedative hypnotic agents ☐ Succinic semialdehyde dehydrogenase deficiency 	5
☐ None of the above	
Prescriber Signature	



EOC ID:

Yonsa-1 Medicare

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

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 application	able):
*Please note that Elixir will process the request as writte	en, including drug name, with	h no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may suppo estions and sign.	ort approval. Please answer the
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 requeste	ed 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	n 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	□ N	ot Applicable



EOC ID:

Yonsa-1 Medicare

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Patient Name:	Prescriber Name:	
Prescriber Signature		



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	e (if applicable):
*Please note that Elixir will process the request as writt	en, including drug n	ame, with no substitution.
	☐ Expedited/L	Irgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following gu	n for this patient that r	nay support approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	herapy
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
 ☐ Autologous peripheral-blood progenitor cell transplant ☐ Chemotherapy-induced febrile neutropenia, prophylax ☐ Hematopoietic subsyndrome of acute radiation syndromenta ☐ Severe chronic neutropenia ☐ Other 	is	r cells for collection by leukapheresis
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Dropprihan Cignatura		Doto
Prescriber Signature		Date



EOC ID:

Zejula-2 Medicare

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

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 requeste	ed medication:			
Advanced or recurrent epithelial ovarian cancer, rec	urrent fallopian tube cancer, or recu	urrent primary peritoneal		
cancer ☐ Advanced ovarian, fallopian tube, or primary periton ☐ Other	eal cancer			
Q4. For ADVANCED OR RECURRENT EPITHELIAL O	VARIAN 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, Of apply to this patient:	R PRIMARY PERITONEAL CANCE	R, please select all that		
☐ 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				



EOC ID:

Zejula-2 Medicare

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Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 chemotherapy ☐ None of the above	6 months after response to the last platinum-based
Q6. If the patient's diagnosis is OTHER, please specify	pelow:
Q7. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q8. Is the requested medication prescribed by (or in consu	ltation with) an oncologist or gynecologist?
☐ Yes	□ No
Prescriber Signature	



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 wr	ritten, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informat	tion for this patient that ma questions and sign.	ay support approval. Please answer the
lonowing	questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erany
		лару
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Chemotherapy-induced febrile neutropenia		
(prophylaxis)	☐ Other	
OA If the neticution diamensis is OTLIED, places and	St. In all account	
Q4. If the patient's diagnosis is OTHER, please speci	iry below:	
Proporihor Signatura		Date
Prescriber Signature		Dale



EOC ID:

Zykadia-2 Medicare

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

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 requ	uest as written, including drug na	ame, with no substitution.
	☐ Expedited/Ui	gent
Drug Name and Strength:		
Directions / SIG:		
Discount and a second a second and a second	on information for this mations that we	av avenue de avenue de Diagne avenue de a
Please attach any pertinent medical history	or information for this patient that m following questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing ther	rany?	
	ару:	
☐ Initial therapy	Continuing th	erapy
☐ Initial therapy	☐ Continuing th	erapy
	☐ Continuing th	erapy
☐ Initial therapy	☐ Continuing th	erapy
☐ Initial therapy	☐ Continuing the provide the start date (MM/YY):	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please	Continuing the provide the start date (MM/YY): r the requested medication:	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m	☐ Continuing the provide the start date (MM/YY): r the requested medication: etastatic ☐ Other	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo	☐ Continuing the provide the start date (MM/YY): r the requested medication: etastatic ☐ Other	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m	☐ Continuing the provide the start date (MM/YY): r the requested medication: etastatic ☐ Other	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m	Continuing the provide the start date (MM/YY): r the requested medication: etastatic	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m Q4. If the patient's diagnosis is OTHER, ple	Continuing the provide the start date (MM/YY): r the requested medication: etastatic	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m Q4. If the patient's diagnosis is OTHER, ple Q5. Is the patient's disease anaplastic lympho ☐ Yes	Continuing the provide the start date (MM/YY): r the requested medication: etastatic	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m Q4. If the patient's diagnosis is OTHER, ple Q5. Is the patient's disease anaplastic lympho ☐ Yes Q6. Is the patient 18 years of age or older?	☐ Continuing the provide the start date (MM/YY): r the requested medication: etastatic ☐ Other ease specify below: oma kinase (ALK)-positive? ☐ No	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m Q4. If the patient's diagnosis is OTHER, ple Q5. Is the patient's disease anaplastic lympho ☐ Yes	Continuing the provide the start date (MM/YY): r the requested medication: etastatic	erapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis fo ☐ Non-small cell lung cancer (NSCLC), m Q4. If the patient's diagnosis is OTHER, ple Q5. Is the patient's disease anaplastic lympho ☐ Yes Q6. Is the patient 18 years of age or older?	Continuing the provide the start date (MM/YY): r the requested medication: etastatic	



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Zykadia-2 Medicare

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Patient Name:	Prescriber Name:
Prescriber Signature	Date