



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Abiraterone-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Metastatic prostate cancer, castration-resistant <input type="checkbox"/> Metastatic prostate cancer, high-risk, castration-sensitive <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the requested medication being used in combination with prednisone? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with an oncologist or urologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Actimmune-1 Medicare

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

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Group Number:	NPI:	State Lic ID:
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City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic granulomatous disease <input type="checkbox"/> Severe malignant osteopetrosis (SMO) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For CHRONIC GRANULOMATOUS DISEASE, will the requested medication be used to reduce the frequency and severity of serious infections?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adempas-2 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 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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic thromboembolic pulmonary hypertension (CTEPH), World Health Organization group 4</p> <p><input type="checkbox"/> Pulmonary arterial hypertension (PAH), World Health Organization group 1</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For CTEPH, please select all that apply to the patient:</p> <p><input type="checkbox"/> Patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy)</p> <p><input type="checkbox"/> Patient's disease is inoperable</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. For PAH, was the diagnosis confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Patient Name:	Prescriber Name:
Q7. For FEMALE PATIENTS, is the patient enrolled in the Adempas REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Q8. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Does the patient have any of the following (please select all that apply)? <input type="checkbox"/> Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form <input type="checkbox"/> Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline) <input type="checkbox"/> Pregnancy <input type="checkbox"/> Pulmonary hypertension associated with idiopathic interstitial pneumonia <input type="checkbox"/> None of the above	

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Afinitor Disperz-1 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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Tuberosus sclerosis complex (TSC)-associated partial-onset seizures</p> <p><input type="checkbox"/> Subependymal giant cell astrocytoma (SEGA) associated with TSC</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For SEGA ASSOCIATED WITH TSC, is the patient a candidate for curative surgical resection?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the requested medication prescribed by, or in consultation with, an oncologist or neurologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
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 (if applicable):	

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Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive as detected by a FDA-approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alecensa-1 Medicare

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Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

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Alkindi-1 Medicare

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

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Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

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Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient require dosages not available with other available formulations of hydrocortisone?
Q6. If the patient has NOT tried other available formulations of hydrocortisone, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?
Q7. Is the patient 18 years of age or younger?
Q8. Is the requested medication being prescribed by or in conjunction with an endocrinologist or pediatrician?



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alpha-1 Proteinase Inhibitor-1 Medicare

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

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Alpha-1 proteinase inhibitor (alpha-1-antitrypsin) deficiency <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have emphysema? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with a pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Does the patient reside in a long-term care (LTC) or hospital setting?



COVERAGE DETERMINATION REQUEST FORM

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Alpha-1 Proteinase Inhibitor-1 Medicare

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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the medication being given via an infusion pump?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Did Medicare pay for the infusion pump?	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	
<input type="checkbox"/> N/A - the medication is not being given via an infusion pump	

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

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Alunbrig-1 Medicare

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Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient 18 years of age or older?
Q6. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

Prescriber Signature

Date



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Alunbrig-1 Medicare

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COVERAGE DETERMINATION REQUEST FORM

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Alyq-1 Medicare

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Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Pulmonary arterial hypertension (PAH) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Was the patient's diagnosis confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Will the patient be concurrently using organic nitrates or guanylate cyclase stimulators (includes intermittent use)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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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? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Pulmonary arterial hypertension (PAH), World Health Organization group 1 <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Was the diagnosis confirmed by right heart catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> 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 with pulmonary hypertension
- None of the above

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Amphetamines-1 Medicare

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

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Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

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Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate which medication is being requested: <input type="checkbox"/> Amphetamine-dextroamphetamine ER <input type="checkbox"/> Dextroamphetamine ER <input type="checkbox"/> Dextroamphetamine IR <input type="checkbox"/> Vyvanse
Q4. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Attention Deficit Hyperactivity disorder (ADHD) <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Other
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. For NARCOLEPSY, has the diagnosis been confirmed by a sleep study? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Amphetamines-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Q8. Please select all that apply to the patient:

- The patient will not be concomitantly using the requested medication with MAOIs or will not use within 14 days of MAOI administration
- The prescriber is a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arcalyst-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient 12 years of age or older?

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Pulmonary Mycobacterium avium complex (MAC) infection <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the requested medication being used as part of a combination antibacterial regimen in a treatment refractory patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with an infectious disease specialist or pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Auryxia-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have chronic kidney disease (CKD)?
Q6. Is the patient on dialysis?
Q7. Is the patient 18 years of age or older?
Q8. Is the requested medication prescribed by or in consultation with a hematologist or nephrologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Auryxia-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chorea associated with Huntington's disease (Huntington's chorea)</p> <p><input type="checkbox"/> Tardive dyskinesia</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the requested medication prescribed by or in consultation with a neurologist or psychiatrist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Hepatic impairment</p> <p><input type="checkbox"/> Suicidal ideation</p>



COVERAGE DETERMINATION REQUEST FORM

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:
<input type="checkbox"/> Untreated or inadequately treated depression <input type="checkbox"/> None of the above	
Q8. Is the patient taking MAOIs, reserpine, or tetrabenazine?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ayvakit-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Gastrointestinal stromal tumor, unresectable or metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is there presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ayvakit-1 Medicare

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

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Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Balversa-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Urothelial carcinoma, locally advanced or metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has susceptible FGFR3 or FGFR2 genetic alterations</p> <p><input type="checkbox"/> The patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with an oncologist or urologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Balversa-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosentan-2 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Pulmonary arterial hypertension, World Health Organization (WHO) group 1 <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have New York Heart Association (NYHA) Functional Class II-IV symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Was the diagnosis confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosentan-2 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosulif-1 Medicare

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

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Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

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Expedited/Urgent checkbox

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?
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select all that apply to the patient:
Q6. Is the patient 18 years of age or older?
Q7. Is the requested medication being prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosulif-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Colorectal cancer, metastatic <input type="checkbox"/> Melanoma, unresectable or metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For COLORECTAL CANCER, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has documented BRAF V600E mutation as detected by a FDA-approved test <input type="checkbox"/> The patient has received prior therapy <input type="checkbox"/> The requested medication will be used in combination with cetuximab (Erbix) <input type="checkbox"/> None of the above</p>
<p>Q6. For MELANOMA, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has documented BRAF V600E or V600K mutation as detected by a FDA-approved test <input type="checkbox"/> The requested medication will be used in combination with binimetinib (Mektovi)</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> None of the above	
Q7. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the requested medication prescribed by or in consultation with an oncologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Mantle cell lymphoma (MCL) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient tried one prior therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient has NOT tried any prior therapies, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?</p>
<p>Q7. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabliivi-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Acquired thrombotic thrombocytopenic purpura (aTTP) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the requested medication being used in combination with plasma exchange and immunosuppression therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabli-1 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabometyx-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Renal cell carcinoma, advanced <input type="checkbox"/> Hepatocellular carcinoma, advanced <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For HEPATOCELLULAR CARCINOMA, has the patient been previously treated with sorafenib (Nexavar)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabometyx-1 Medicare

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

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COVERAGE DETERMINATION REQUEST FORM

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 Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic lymphocytic leukemia (CLL) <input type="checkbox"/> Mantle cell lymphoma (MCL) <input type="checkbox"/> Small lymphocytic lymphoma (SLL) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For MANTLE CELL LYMPHOMA, has the patient tried at least one other therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Calquence-1 Medicare

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

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Prescriber Name:

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Caprelsa-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient's disease metastatic or unresectable, locally advanced?
Q6. Is the patient's disease symptomatic or progressive?
Q7. Is the patient 18 years of age or older?
Q8. Does the patient have congenital long QT syndrome?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Caprelsa-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cayston-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Was the patient's diagnosis confirmed by appropriate diagnostic or genetic testing?
Q6. Does the patient have suspected or confirmed Pseudomonas aeruginosa infection?
Q7. Is the patient 7 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cayston-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cinryze-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Hereditary angioedema (HAE) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select all that apply to the patient:</p> <p><input type="checkbox"/> The requested medication is being used in prevention of angioedema attacks</p> <p><input type="checkbox"/> The requested medication is being used in prevention of acute abdominal, facial, or laryngeal attacks</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 6 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with a hematologist, immunologist, or allergist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cinryze-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
CNS Stimulants-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Narcolepsy <input type="checkbox"/> Obstructive sleep apnea (OSA) <input type="checkbox"/> Shift work disorder (SWD) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For NARCOLEPSY or OBSTRUCTIVE SLEEP APNEA, was the patient's diagnosis confirmed by sleep lab evaluation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
CNS Stimulants-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cometriq-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication below:</p> <p><input type="checkbox"/> Medullary thyroid cancer (progressive, metastatic) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Copiktra-1 Medicare

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

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Chronic lymphocytic leukemia <input type="checkbox"/> Follicular lymphoma <input type="checkbox"/> Small lymphocytic lymphoma <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient's disease relapsed or refractory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Does the patient have a history of at least two prior therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. If the patient has NOT tried two prior therapies, is there a reason why (i.e., contraindication, history of adverse event, etc.)?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Copiktra-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-1 Medicare

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

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Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For CHRONIC HEART FAILURE, please select all that apply to the patient:
Q6. For HEART FAILURE DUE TO DILATED CARDIOMYOPATHY, is the patient in sinus rhythm with an elevated heart rate?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-1 Medicare

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

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

Patient Name:	Prescriber Name:
----------------------	-------------------------

Yes

No

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

Bradycardia (i.e., resting heart rate is less than 60 beats per minute prior to treatment)

Decompensated acute heart failure

Hypotension (i.e., blood pressure less than 90/50 mmHg)

Severe hepatic impairment (Child-Pugh C)

Sick sinus syndrome, sinoatrial block, or 3rd degree AV block (unless a functioning demand pacemaker is present)

None of the above

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-3 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Non-radiographic axial spondyloarthritis <input type="checkbox"/> Plaque psoriasis, moderate to severe <input type="checkbox"/> Psoriatic arthritis, active <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient failed or is intolerant to any of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> None of the above</p>
<p>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.)?</p>
<p>Q7. Was the patient screened for latent tuberculosis prior to initiation of treatment?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-3 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-2 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have BRAF V600E or V600K mutation?
Q6. Is the requested medication being used in combination with vemurafenib (Zelboraf)?

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-2 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Cystinosis <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have corneal cystine crystal accumulation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have demonstrated hypersensitivity to cysteamine or penicillamine?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-2 Medicare

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

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

Patient Name:

Prescriber Name:

hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dalfampridine-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Does the patient have any of the following? (Please select all that apply.)



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dalfampridine-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Daurismo-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Acute myeloid leukemia (AML), newly diagnosed <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the requested medication being used in combination with cytarabine? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 75 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the requested medication prescribed by or in consultation with an oncologist or hematologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Daurismo-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Deferasirox-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Chronic iron overload due to blood transfusions (transfusion hemosiderosis) <input type="checkbox"/> Chronic iron overload in non-transfusion-dependent thalassemia syndromes <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS, please select all that apply to the patient: <input type="checkbox"/> The patient has had transfusion of at least 100 mL/kg packed red blood cells <input type="checkbox"/> The patient has serum ferritin level greater than 1000 mcg/L <input type="checkbox"/> None of the above
Q6. For CHRONIC IRON OVERLOAD IN NON-TRANSFUSION-DEPENDENT THALASSEMIA SYNDROMES, please select all that apply to the patient: <input type="checkbox"/> The patient has liver iron concentrations of at least 5 mg Fe/g dry weight <input type="checkbox"/> The patient has serum ferritin level greater than 300 mcg/L



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Deferasirox-1 Medicare

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

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

Patient Name:	Prescriber Name:
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None of the above

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Diacomit-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Severe myoclonic epilepsy in infancy (Dravet syndrome) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient taking clobazam? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the requested medication being prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Diacomit-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Diclofenac Topical-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Actinic keratosis <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dojolvi-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Long-chain fatty acid oxidation disorder (LC-FAOD) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dronabinol-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Anorexia associated to AIDS <input type="checkbox"/> Chemotherapy-induced nausea and vomiting <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have sesame oil hypersensitivity?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the oral anti-nausea drug being used as part of an anti-cancer chemotherapeutic regimen?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the oral drug being used as a full therapeutic replacement for an intravenous anti-nausea drug administered within 48 hours of chemotherapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dronabinol-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID: Dupixent-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For ASTHMA, please select all that apply to this patient:
Q6. For ASTHMA or RHINOSINUSITIS, is the requested medication being used as adjunct treatment?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dupixent-1 Medicare

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

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

Patient Name:	Prescriber Name:
----------------------	-------------------------

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

Yes

No

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

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-2 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For PLAQUE PSORIASIS, is the patient a candidate for systemic therapy (such as the requested medication) or phototherapy?
Q6. Has the patient been screened for latent tuberculosis infection prior to initiation of treatment?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Endari-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Acute sickle cell disease <input type="checkbox"/> Short bowel syndrome <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For SHORT BOWEL SYNDROME, is the requested medication being used in combination with recombinant human growth hormone?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 5 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Endari-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enspryng-3 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Neuromyelitis optica spectrum disorder (NMOSD) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient anti-aquaporin-4 (AQP4) antibody positive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with a neurologist, immunologist, or ophthalmologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Does the patient have any of the following? (Please select all that apply.)



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enspryng-3 Medicare

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

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

Patient Name:

Prescriber Name:

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Entresto-3 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Chronic heart failure <input type="checkbox"/> Symptomatic heart failure <input type="checkbox"/> Other
Q4. For CHRONIC HEART FAILURE, does the patient have New York Heart Association (NYHA) class II-IV heart failure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. For SYMPTOMATIC HEART FAILURE, does the patient have systemic left ventricular systolic dysfunction? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Does the patient have any of the following? (Please select all that apply.) <input type="checkbox"/> History of angioedema related to previous ACE inhibitor or ARB therapy <input type="checkbox"/> Concomitant use or use within 36 hours of an ACE inhibitor <input type="checkbox"/> Concomitant use of aliskiren (Tekturna) in a patient with diabetes <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Entresto-3 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epidiolex-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Lennox-Gastaut syndrome <input type="checkbox"/> Seizures associated with tuberous sclerosis complex <input type="checkbox"/> Severe myoclonic epilepsy in infancy (Dravet syndrome) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the requested medication prescribed by or in consultation with a neurologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epidiolex-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epoetin Therapy-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial therapy or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Anemia associated with chronic kidney disease (CKD), on dialysis <input type="checkbox"/> Anemia associated with chronic kidney disease (CKD), not on dialysis <input type="checkbox"/> Anemia associated with myelosuppressive chemotherapy <input type="checkbox"/> Anemia associated with zidovudine therapy in a patient with HIV infection <input type="checkbox"/> Reduction of blood transfusions in a patient undergoing elective, non-cardiac, non-vascular surgery who is at high risk for perioperative blood loss <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient's pre-treatment hemoglobin level less than 10 g/dL? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Will there be a dose reduction or interruption if hemoglobin exceeds one of the following: 10 g/dL (adult CKD not on dialysis, or cancer), 11 g/dL (CKD on dialysis), or 12 g/dL (pediatric CKD)?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epoetin Therapy-2 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable - the patient has a different diagnosis	
Q7. Does the patient have end stage renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Did the dialysis center receive a bundled payment for dialysis and dialysis medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erleada-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Metastatic, castration-sensitive prostate cancer <input type="checkbox"/> Nonmetastatic, castration-resistant prostate cancer <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the requested medication prescribed by or in consultation with an oncologist or urologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erleada-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erlotinib-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-small cell lung cancer (locally advanced or metastatic)</p> <p><input type="checkbox"/> Pancreatic cancer (locally advanced, unresectable or metastatic)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For NON-SMALL CELL LUNG CANCER, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by a FDA-approved test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility</p> <p><input type="checkbox"/> The requested medication will be used as first-line treatment</p> <p><input type="checkbox"/> The patient had failure with at least one prior chemotherapy regimen</p> <p><input type="checkbox"/> The patient has no evidence of disease progression after four cycles of first-line platinum-based chemotherapy and the requested medication will be used as maintenance treatment</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erlotinib-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q6. For PANCREATIC CANCER, is the requested medication being used in combination with gemcitabine?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the requested medication prescribed by or in consultation with an oncologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID: Everolimus-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For BREAST CANCER, please select all that apply to the patient:



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Everolimus-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> None of the above	
Q6. For RENAL CELL CARCINOMA, has the patient had failure with sunitinib (Sutent) or sorafenib (Nexavar)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the requested medication prescribed by or in consultation with an oncologist or neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Evrysdi-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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.

Five question boxes (Q1-Q5) regarding therapy type, start date, diagnosis, and neurologist consultation.

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Farydak-2 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the requested medication being used in combination with bortezomib (Velcade) and dexamethasone?
Q6. Has the patient received at least two prior treatment regimens, including bortezomib (Velcade) and an immunomodulatory agent [e.g., lenalidomide (Revlimid), thalidomide (Thalomid)]?
Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Farydak-2 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the requested medication prescribed by or in consultation with an oncologist or hematologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl Oral-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Cancer-related breakthrough pain <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient currently receiving or is tolerant to around-the-clock opioid therapy for persistent cancer pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Are the patient and prescriber enrolled in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation Mitigation Strategy (REMS) Access Program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the patient 16 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Will the requested medication be used for any of the following? (Please select all that apply.)



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl Oral-1 Medicare

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

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

Patient Name:

Prescriber Name:

- Management of acute or postoperative pain (including headache/migraine, dental pain, or use in the emergency room)
- Use in an opioid non-tolerant patient
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fintepla-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Severe myoclonic epilepsy in infancy (Dravet syndrome) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the requested medication prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient using the requested medication concomitantly with a monoamine oxidase inhibitor (MAOI) or within 14 days of discontinuing a MAOI? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fintepla-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firazyr-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Will the requested medication be used for the treatment of acute attacks?
Q6. Is the patient 18 years of age or older?
Q7. Is the requested medication prescribed by or in consultation with a hematologist, immunologist, or allergist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firazyr-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firdapse-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Lambert-Eaton myasthenic syndrome (LEMS) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have a history of seizures?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firdapse-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fotivda-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Advanced renal cell cancer (RCC), relapsed or refractory <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient received 2 or more prior systemic therapies?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient has NOT tried 2 or more prior systemic therapies, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fotivda-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID: Galafold-1 Medicare

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

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

Form with two columns: Patient Name (Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone) and Prescriber Name (Fax, Phone, Office Contact, NPI, State Lic ID, Address, City, State ZIP, Specialty/facility name).

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have an amenable galactosidase alpha gene (GLA) mutation?
Q6. Is the patient 16 years of age or older?

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Galafold-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gattex-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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.

Five question boxes (Q1-Q5) regarding therapy type, start date, diagnosis, and parenteral nutrition.

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gavreto-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic, RET fusion-positive</p> <p><input type="checkbox"/> Medullary thyroid cancer (MTC), advanced or metastatic, RET-mutant</p> <p><input type="checkbox"/> Thyroid cancer, advanced or metastatic, RET fusion-positive</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. FOR NON-SMALL CELL LUNG CANCER, was the patient's diagnosis detected by a FDA-approved test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. FOR THYROID CANCER, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient requires systemic therapy (such as the requested medication)</p> <p><input type="checkbox"/> The patient is radioactive iodine-refractory, when radioactive iodine is appropriate</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gavreto-2 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gilotrif-2 Medicare

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

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Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***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? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select all that apply to the patient: <input type="checkbox"/> The patient's tumors have nonresistant epidermal growth factor receptor (EGFR) mutations as detected by a FDA-approved test <input type="checkbox"/> The patient has squamous NSCLC with progression after platinum-based chemotherapy <input type="checkbox"/> None of the above
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gilotrif-2 Medicare

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Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gocovri-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Extrapyramidal disease <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For PARKINSON'S DISEASE, please select all that apply to this patient:</p> <p><input type="checkbox"/> Patient is experiencing dyskinesia <input type="checkbox"/> Patient is receiving levodopa-based therapy <input type="checkbox"/> None of the above</p>
<p>Q6. Does the patient have a documented trial and failure of amantadine immediate release?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. If the patient has NOT tried amantadine immediate release, is there a reason why this medication cannot be used</p>



COVERAGE DETERMINATION REQUEST FORM

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Gocovri-1 Medicare

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Patient Name:	Prescriber Name:
(i.e., contraindication, history of adverse event, etc.)?	
Q8. Is the requested medication prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Does the patient have end stage renal disease (ESRD, CrCl below 15 mL/min/m ²)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>										
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>										
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <table border="0"> <tr> <td><input type="checkbox"/> Chronic renal insufficiency (CRI), pediatric</td> <td><input type="checkbox"/> Prader-Willi syndrome, pediatric</td> </tr> <tr> <td><input type="checkbox"/> Growth hormone deficiency (GHD), adult</td> <td><input type="checkbox"/> Short-stature homeobox-containing gene (SHOX) deficiency, pediatric</td> </tr> <tr> <td><input type="checkbox"/> Growth hormone deficiency (GHD), pediatric</td> <td><input type="checkbox"/> Small for gestational age (SGA), pediatric</td> </tr> <tr> <td><input type="checkbox"/> Idiopathic short stature, pediatric</td> <td><input type="checkbox"/> Turner syndrome</td> </tr> <tr> <td><input type="checkbox"/> Noonan syndrome, pediatric</td> <td><input type="checkbox"/> Other</td> </tr> </table>	<input type="checkbox"/> Chronic renal insufficiency (CRI), pediatric	<input type="checkbox"/> Prader-Willi syndrome, pediatric	<input type="checkbox"/> Growth hormone deficiency (GHD), adult	<input type="checkbox"/> Short-stature homeobox-containing gene (SHOX) deficiency, pediatric	<input type="checkbox"/> Growth hormone deficiency (GHD), pediatric	<input type="checkbox"/> Small for gestational age (SGA), pediatric	<input type="checkbox"/> Idiopathic short stature, pediatric	<input type="checkbox"/> Turner syndrome	<input type="checkbox"/> Noonan syndrome, pediatric	<input type="checkbox"/> Other
<input type="checkbox"/> Chronic renal insufficiency (CRI), pediatric	<input type="checkbox"/> Prader-Willi syndrome, pediatric									
<input type="checkbox"/> Growth hormone deficiency (GHD), adult	<input type="checkbox"/> Short-stature homeobox-containing gene (SHOX) deficiency, pediatric									
<input type="checkbox"/> Growth hormone deficiency (GHD), pediatric	<input type="checkbox"/> Small for gestational age (SGA), pediatric									
<input type="checkbox"/> Idiopathic short stature, pediatric	<input type="checkbox"/> Turner syndrome									
<input type="checkbox"/> Noonan syndrome, pediatric	<input type="checkbox"/> Other									
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>										
<p>Q5. For CHRONIC RENAL INSUFFICIENCY, please select all that apply to the patient:</p> <p><input type="checkbox"/> Nutritional status has been optimized</p> <p><input type="checkbox"/> Metabolic abnormalities have been corrected</p> <p><input type="checkbox"/> The patient has not had renal transplant</p> <p><input type="checkbox"/> None of the above</p>										



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

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

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

Patient Name:	Prescriber Name:												
<p>Q6. For PEDIATRIC GROWTH HORMONE DEFICIENCY, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient's bone age is at least 1 year or 2 standard deviations (SD) delayed compared with chronological age</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> None of the above</p>													
<p>Q7. For PRADER-WILLI SYNDROME, was the diagnosis confirmed by genetic testing?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>													
<p>Q8. For SMALL FOR GESTATIONAL AGE, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient's birth weight or length is 2 or more standard deviations (SD) below mean for gestational age</p> <p><input type="checkbox"/> The patient failed to manifest catch up growth by age 2 (height 2 or more SD below mean for age and gender)</p> <p><input type="checkbox"/> None of the above</p>													
<p>Q9. For TURNER SYNDROME, was the diagnosis confirmed by chromosome analysis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>													
<p>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:</p> <p><input type="checkbox"/> The patient's height is more than 3 standard deviations (SD) below mean for age and gender</p> <p><input type="checkbox"/> The patient's height is more than 2 SD below mean with growth velocity (GV) more than 1 SD below mean</p> <p><input type="checkbox"/> The patient's GV over 1 year is 2 SD below mean</p> <p><input type="checkbox"/> None of the above</p>													
<p>Q11. For ADULT GROWTH HORMONE DEFICIENCY (GHD), please select all that apply to the patient:</p> <table border="0"><tr><td><input type="checkbox"/> The patient has childhood or adult-onset GHD confirmed by 2 standard growth hormone (GH) stimulation tests</td><td><input type="checkbox"/> The patient has a subnormal IGF-1 (after at least 1 month off GH therapy)</td></tr><tr><td><input type="checkbox"/> The patient had an insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L)</td><td><input type="checkbox"/> The patient has objective evidence of GHD complications, such as low bone density, increased visceral fat mass, or cardiovascular complications</td></tr><tr><td><input type="checkbox"/> Insulin tolerance tests are contraindicated, and the patient had a standardized stimulation test (such as arginine plus GH releasing hormone [preferred], glucagon, arginine)</td><td><input type="checkbox"/> The patient has completed linear growth (growth velocity [GV] less than 2 cm/year)</td></tr><tr><td><input type="checkbox"/> The patient has at least 1 other pituitary hormone deficiency and failed at least 1 GH stimulation test (ITT preferred)</td><td><input type="checkbox"/> Growth hormone has been discontinued for at least 1 month (if previously receiving GH)</td></tr><tr><td><input type="checkbox"/> The patient has panhypopituitarism (3 or more pituitary hormone deficiencies)</td><td><input type="checkbox"/> None of the above</td></tr><tr><td><input type="checkbox"/> The patient has irreversible hypothalamic-pituitary</td><td></td></tr></table>		<input type="checkbox"/> The patient has childhood or adult-onset GHD confirmed by 2 standard growth hormone (GH) stimulation tests	<input type="checkbox"/> The patient has a subnormal IGF-1 (after at least 1 month off GH therapy)	<input type="checkbox"/> The patient had an insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L)	<input type="checkbox"/> The patient has objective evidence of GHD complications, such as low bone density, increased visceral fat mass, or cardiovascular complications	<input type="checkbox"/> Insulin tolerance tests are contraindicated, and the patient had a standardized stimulation test (such as arginine plus GH releasing hormone [preferred], glucagon, arginine)	<input type="checkbox"/> The patient has completed linear growth (growth velocity [GV] less than 2 cm/year)	<input type="checkbox"/> The patient has at least 1 other pituitary hormone deficiency and failed at least 1 GH stimulation test (ITT preferred)	<input type="checkbox"/> Growth hormone has been discontinued for at least 1 month (if previously receiving GH)	<input type="checkbox"/> The patient has panhypopituitarism (3 or more pituitary hormone deficiencies)	<input type="checkbox"/> None of the above	<input type="checkbox"/> The patient has irreversible hypothalamic-pituitary	
<input type="checkbox"/> The patient has childhood or adult-onset GHD confirmed by 2 standard growth hormone (GH) stimulation tests	<input type="checkbox"/> The patient has a subnormal IGF-1 (after at least 1 month off GH therapy)												
<input type="checkbox"/> The patient had an insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L)	<input type="checkbox"/> The patient has objective evidence of GHD complications, such as low bone density, increased visceral fat mass, or cardiovascular complications												
<input type="checkbox"/> Insulin tolerance tests are contraindicated, and the patient had a standardized stimulation test (such as arginine plus GH releasing hormone [preferred], glucagon, arginine)	<input type="checkbox"/> The patient has completed linear growth (growth velocity [GV] less than 2 cm/year)												
<input type="checkbox"/> The patient has at least 1 other pituitary hormone deficiency and failed at least 1 GH stimulation test (ITT preferred)	<input type="checkbox"/> Growth hormone has been discontinued for at least 1 month (if previously receiving GH)												
<input type="checkbox"/> The patient has panhypopituitarism (3 or more pituitary hormone deficiencies)	<input type="checkbox"/> None of the above												
<input type="checkbox"/> The patient has irreversible hypothalamic-pituitary													



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

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

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

Patient Name:	Prescriber Name:
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structural lesions due to tumors, surgery, or radiation of pituitary or hypothalamus region

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

Q13. Is the requested medication prescribed by or in consultation with an endocrinologist or nephrologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Q14. Does the patient have any of the following? (Please select all that apply.) <input type="checkbox"/> The requested medication is being used for growth promotion in pediatric patients with closed epiphyses <input type="checkbox"/> Acute critical illness caused by complications following open-heart or abdominal surgery, multiple accidental trauma, or acute respiratory failure <input type="checkbox"/> Active malignancy <input type="checkbox"/> Active proliferative or severe non-proliferative diabetic retinopathy <input type="checkbox"/> Prader-Willi Syndrome in patients who are severely obese, have a history of upper airway obstruction or sleep apnea, or have severe respiratory impairment <input type="checkbox"/> None of the above
--

_____ Prescriber Signature	_____ Date
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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepatitis C-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please provide the patient's genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy:
Q6. Has the prescriber documented the following within 12 weeks of initiating therapy: CBC, INR, hepatic function panel, and GFR?
Q7. Is the patient post-transplant?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepatitis C-1 Medicare

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

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Patient Name:	Prescriber Name:
Q8. What is the patient's cirrhosis status?	
Q9. What is the patient's prior treatment history (if any)?	
Q10. What is the patient's planned duration of treatment?	
Q11. Is the requested medication prescribed by, or in consultation with, one of the following (please select any that apply)? <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> None of the above	
Q12. For Vosevi: Has the patient had trial and failure, contraindication, or intolerance to Mavyret or Sofosbuvir/Velpatasvir (Epclusa)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Q13. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hetlioz-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Muscle Relaxants-3 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Acute painful musculoskeletal conditions <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 65 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-2 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For CROHN'S DISEASE, has the patient had an inadequate response to conventional therapy?
Q6. For PLAQUE PSORIASIS, is the patient a candidate for systemic therapy or phototherapy, and are other systemic therapies medically less appropriate?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-2 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. For ULCERATIVE COLITIS, has the patient had an inadequate response to immunosuppressants (e.g., corticosteroids, azathioprine)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. If the patient has NOT tried any of the medications listed in the previous question(s), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?	
Q9. Has the patient been screened for latent tuberculosis infection prior to initiation of treatment?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ibrance-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Breast cancer, advanced or metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Please indicate how the requested medication will be used:</p> <p><input type="checkbox"/> In combination with an aromatase inhibitor in a postmenopausal woman or man</p> <p><input type="checkbox"/> In combination with fulvestrant (Faslodex) for disease progression following endocrine therapy</p> <p><input type="checkbox"/> None of the above</p>
<p>Q7. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ibrance-1 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:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iclusig-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic myeloid leukemia (CML), chronic, accelerated, or blast phase</p> <p><input type="checkbox"/> Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient T315I-positive?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is no other tyrosine kinase inhibitor therapy indicated for the patient?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

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Iclusig-1 Medicare

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Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Idhifa-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Acute myeloid leukemia (AML), relapsed or refractory <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have an isocitrate dehydrogenase 2 mutation as detected by a FDA-approved test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Idhifa-1 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Imbruvica-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic graft-versus-host disease (cGVHD)</p> <p><input type="checkbox"/> Chronic lymphocytic leukemia (CLL), with or without 17p deletion</p> <p><input type="checkbox"/> Mantle cell lymphoma (MCL)</p> <p><input type="checkbox"/> Marginal zone lymphoma</p> <p><input type="checkbox"/> Small lymphocytic lymphoma (SLL), with or without 17p deletion</p> <p><input type="checkbox"/> Waldenstrom macroglobulinemia</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For GRAFT-VERSUS-HOST DISEASE, has the patient failed at least one first-line corticosteroid therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For MANTLE CELL LYMPHOMA, has the patient received at least one prior therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

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Imbruvica-2 Medicare

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

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Patient Name:

Prescriber Name:

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

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

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

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

- Yes
- No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inbrija-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Will the requested medication be used concurrently with carbidopa/levodopa?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has the patient tried and failed or has a contraindication to one generic formulary alternative?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. If the patient has NOT tried one generic formulary alternative, is there a reason why it cannot be used (i.e., contraindication, history of adverse event, etc.)?</p>
<p>Q8. Is the patient 18 years old or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inbrija-1 Medicare

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

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Patient Name:	Prescriber Name:
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Yes

No

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Increlex-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is the request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Treatment of growth failure in a pediatric patient <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have any of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> Severe primary insulin-like growth factor-1 (IGF-1) deficiency</p> <p><input type="checkbox"/> Growth hormone (GH) gene deletion and the patient has developed neutralizing antibodies to GH</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Please select any of the following that apply to the patient:</p> <p><input type="checkbox"/> The patient has active or suspected malignancy</p> <p><input type="checkbox"/> The requested medication will be used for growth promotion in a patient with closed epiphyses</p> <p><input type="checkbox"/> The requested medication will be administered intravenously</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Increlex-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inqovi-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient 18 years of age or older?
Q6. Is the requested medication prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inqovi-1 Medicare

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

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Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inrebic-2 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient 18 years of age or older?
Q6. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inrebic-2 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Intrarosa-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Moderate to severe dyspareunia due to menopause <input type="checkbox"/> Atrophic vaginitis due to menopause <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Does the patient have any of the following? (Please select all that apply.) <input type="checkbox"/> Known or suspected estrogen-dependent neoplasia <input type="checkbox"/> Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

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Intrarosa-1 Medicare

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Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID: Iressa-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient's tumor have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility?
Q6. Is the requested medication being used as first-line treatment?

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iressa-1 Medicare

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

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Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Isturisa-2 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is pituitary surgery not an option or has not been curative for the patient?
Q6. Is the patient 18 years of age or older?
Q7. Is the requested medication prescribed by or in consultation with an endocrinologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Isturisa-2 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Itraconazole-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the drug that is being requested below: <input type="checkbox"/> Itraconazole capsules <input type="checkbox"/> Itraconazole solution
Q4. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Candidiasis (esophageal or oropharyngeal) <input type="checkbox"/> Onychomycosis <input type="checkbox"/> Systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis) <input type="checkbox"/> Other
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. For CANDIDIASIS, is the disease refractory to treatment with fluconazole? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. If the patient has NOT tried fluconazole, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Itraconazole-1 Medicare

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

Yes

No

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

Ventricular dysfunction (e.g., congestive heart failure [CHF] or history of CHF)

Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.)

None of the above

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
IVIG-1 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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic inflammatory demyelinating polyneuropathy (CIDP)</p> <p><input type="checkbox"/> Idiopathic or chronic immune thrombocytopenic purpura</p> <p><input type="checkbox"/> Motor neuropathy with multiple conduction block</p> <p><input type="checkbox"/> Prevention of bacterial infection in patients with hypogammaglobulinemia or recurrent bacterial infections with B-cell chronic lymphocytic leukemia (CLL)</p> <p><input type="checkbox"/> Prevention of coronary artery aneurysms associated with Kawasaki syndrome</p> <p><input type="checkbox"/> Primary humoral immunodeficiency (congenital agammaglobulinemia, severe combined immunodeficiency syndromes [SCIDS], common variable immunodeficiency, X-linked immunodeficiency, Wiskott-Aldrich syndrome)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have any of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> History of anaphylaxis or severe systemic reaction to human immune globulin</p> <p><input type="checkbox"/> IgA deficiency with antibody formation and a history of hypersensitivity</p>



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Patient Name:	Prescriber Name:
<input type="checkbox"/> None of the above	
Q6. Does the patient have primary immune deficiency disease? (One of these ICD-10 codes: D80.0; D80.5; D83.8; D83.9; D82.0; D81.0; D81.1; D81.2; D81.89; D81.9; G11.3; D80.2; D80.3; D80.4; D80.6; D80.7; D81.5; D81.6; D81.7; D82.1; D82.4; D83.0; D83.1; D83.2)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the medication being administered in the patient's home?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Jakafi-1 Medicare

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

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Acute graft-versus-host disease <input type="checkbox"/> Intermediate or high risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis <input type="checkbox"/> Polycythemia vera <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For GRAFT-VERSUS-HOST DISEASE, is the disease refractory to steroid therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. For POLYCYTHEMIA VERA, has the patient had an inadequate response to or is intolerant to hydroxyurea? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. If the patient has NOT tried hydroxyurea, is there a reason why this medication cannot be used (i.e.,



COVERAGE DETERMINATION REQUEST FORM

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Jakafi-1 Medicare

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Patient Name:

Prescriber Name:

contraindication, history of adverse event, etc.)?

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Juxtapid-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Homozygous familial hypercholesterolemia (HoFH) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient's diagnosis been confirmed by any of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (LDLRAP1 or ARH)</p> <p><input type="checkbox"/> The patient has untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL</p> <p><input type="checkbox"/> Xanthoma before 10 years of age</p> <p><input type="checkbox"/> Evidence of heterozygous familial hypercholesterolemia in both parents</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Juxtapid-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:

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

- The patient has moderate or severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests
- The patient is pregnant
- The requested medication will be used concomitantly with strong or moderate CYP3A4 inhibitors
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kalydeco-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Cystic fibrosis (CF) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the requested medication prescribed by or in consultation with a pulmonologist or is the prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kalydeco-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kesimpta-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient 18 years of age or older?
Q6. Is the requested medication prescribed by or in consultation with a neurologist?
Q7. Does the patient have active hepatitis B infection?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kesimpta-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kisqali-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate which medication this request is for below:
Q4. Please indicate the patient's diagnosis for the requested medication:
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?
Q7. Please indicate the patient's menopause status:



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kisqali-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. For KISQALI, will the requested medication be used in combination with any of the following? <input type="checkbox"/> An aromatase inhibitor <input type="checkbox"/> Fulvestrant <input type="checkbox"/> None of the above	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Korlym-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Endogenous Cushing's syndrome <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has type 2 diabetes mellitus or glucose intolerance</p> <p><input type="checkbox"/> The requested medication is being used to control hyperglycemia secondary to hypercortisolism</p> <p><input type="checkbox"/> The patient has failed surgery</p> <p><input type="checkbox"/> The patient is not a candidate for surgery</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with an endocrinologist?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Korlym-1 Medicare

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

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Patient Name:	Prescriber Name:
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Yes

No

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Koselugo-2 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have symptomatic, inoperable plexiform neurofibromas (PN)?
Q6. Is the patient between 2 to 17 years of age?
Q7. Is the requested medication prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Koselugo-2 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kuvan/Sapropterin-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lenvima-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Endometrial carcinoma, advanced <input type="checkbox"/> Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer <input type="checkbox"/> Renal cell carcinoma, advanced <input type="checkbox"/> Unresectable hepatocellular carcinoma, first-line therapy <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For ENDOMETRIAL CARCINOMA, please select all that apply to this patient: <input type="checkbox"/> The patient's disease is NOT microsatellite instability-high or mismatch repair deficient <input type="checkbox"/> The requested medication will be used in combination with pembrolizumab (Keytruda) <input type="checkbox"/> The patient's disease has progressed following prior systemic therapy <input type="checkbox"/> The patient is not a candidate for curative surgery or radiation <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lenvima-1 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:

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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leukine-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Acute myeloid leukemia, following completion of induction chemotherapy</p> <p><input type="checkbox"/> Allogeneic or autologous bone marrow transplant, delayed or failed engraftment</p> <p><input type="checkbox"/> Autologous peripheral blood progenitor cell transplant, mobilization of progenitor cells for collection by leukapheresis</p> <p><input type="checkbox"/> Autologous peripheral blood stem cell transplant, following myeloablative chemotherapy</p> <p><input type="checkbox"/> Hematopoietic subsyndrome of acute radiation syndrome (H-ARS)</p> <p><input type="checkbox"/> Myeloid reconstitution after autologous or allogeneic bone marrow transplant</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leukine-1 Medicare

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

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Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leuprolide-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Anemia due to uterine leiomyomata (fibroids), preoperative <input type="checkbox"/> Central precocious puberty (idiopathic or neurogenic) in children <input type="checkbox"/> Endometriosis <input type="checkbox"/> Prostate cancer, advanced or metastatic <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. If the patient has NOT tried Eligard, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?
Q7. Will this medication be administered in a physician's office?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leuprolide-2 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Will the physician's office furnish the medication from their stock?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Will the patient get the medication from a pharmacy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lidocaine Patch-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Pain associated with cancer-related neuropathy</p> <p><input type="checkbox"/> Pain associated with diabetic peripheral neuropathy</p> <p><input type="checkbox"/> Postherpetic neuralgia</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Osteoarthritis of the knee or hip</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lonsurf-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For COLORECTAL CANCER, does the patient have RAS wild-type?
Q6. For COLORECTAL CANCER, has the patient been previously treated with any of the following? (Please select all that apply.)



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lonsurf-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?	
Q8. For GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA, has the patient been previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lorbrena-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has the patient had disease progression on any of the following for metastatic disease? (Please select all that apply.)</p> <p><input type="checkbox"/> Alectinib (Alecensa) as the first ALK inhibitor</p> <p><input type="checkbox"/> Ceritinib (Zykadia) as the first ALK inhibitor</p> <p><input type="checkbox"/> Crizotinib (Xalkori) and at least 1 other ALK inhibitor</p> <p><input type="checkbox"/> None of the above</p>
<p>Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lorbrena-1 Medicare

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

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

Patient Name:	Prescriber Name:
medications cannot be used (i.e., contraindication, history of adverse event, etc.)?	
Q8. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Will the requested medication be used concomitantly with strong CYP3A4 inducers? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-small cell lung cancer (NSCLC), KRAS G12C-mutated locally advanced or metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the KRAS G12C mutation been determined by an FDA-approved test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has the patient received at least one prior systemic therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. If the patient has NOT tried at least one prior systemic therapy, is there a reason why these medications cannot</p>



COVERAGE DETERMINATION REQUEST FORM

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the requested medication being prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupkynis-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Systemic lupus erythematosus (SLE) with active lupus nephritis (LN) Classes III, IV, V (alone or in combination) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. FOR INITIAL THERAPY, please select all that apply to the patient:</p> <p><input type="checkbox"/> Patient has a baseline renal function of 45 mL/min/1.73 m2 or greater</p> <p><input type="checkbox"/> The requested medication will be used in combination with a background immunosuppressive therapy regimen (e.g. mycophenolate, oral steroids, etc)</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. FOR CONTINUING THERAPY, please select all that apply to the patient:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupkynis-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> The patient had improvement in urine protein to creatinine ratio (UPCR) (i.e. 0.5 mg/mg or less)	
<input type="checkbox"/> The patient has an estimated glomerular filtration rate (eGFR) of 60 mL/min/1.73 m ² or greater, or there is no confirmed decrease from baseline in eGFR of greater than 20%	
<input type="checkbox"/> None of the above	
Q7. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the requested medication being prescribed by or in consultation with a rheumatologist or nephrologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested medication being used concomitantly with strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lynparza-2 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Advanced ovarian cancer <input type="checkbox"/> Breast cancer, metastatic <input type="checkbox"/> Epithelial ovarian, fallopian tube, or primary peritoneal cancer <input type="checkbox"/> Pancreatic adenocarcinoma, metastatic <input type="checkbox"/> Prostate cancer, metastatic castration-resistant <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For ADVANCED OVARIAN CANCER, please select all that apply to this patient: <input type="checkbox"/> The patient has known or suspected BRCA mutation as detected by a FDA-approved test <input type="checkbox"/> The patient has trial and failure, contraindication, or intolerance to 3 or more prior lines of chemotherapy <input type="checkbox"/> None of the above
Q6. For BREAST CANCER, please select all that apply to this patient:



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lynparza-2 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 is human epidermal growth factor receptor 2 (HER2)-negative
- The patient has deleterious or suspected deleterious germline BRCA mutation (gBRCAm)
- The patient has been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting
- None of the above

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

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

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

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mayzent-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Relapsing forms of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient had history of or contraindication to any of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron <input type="checkbox"/> Copaxone <input type="checkbox"/> Gilenya <input type="checkbox"/> Tecfidera <input type="checkbox"/> None of the above</p>
<p>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.)?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mayzent-1 Medicare

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

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

Patient Name:	Prescriber Name:
----------------------	-------------------------

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

Yes

No

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

Yes

No

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

CYP2C9*3/*3 genotype

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

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

None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
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? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Anaplastic thyroid cancer, locally advanced or metastatic <input type="checkbox"/> Malignant melanoma <input type="checkbox"/> Non-small cell lung cancer, metastatic <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For ANAPLASTIC THYROID CANCER, does the patient have no locoregional treatment options? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. For ANAPLASTIC THYROID CANCER OR NON-SMALL CELL LUNG CANCER, does the patient have BRAF V600E mutation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. For MALIGNANT MELANOMA, please select all that apply to this patient:



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mekinist-2 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> The patient has BRAF V600E or V600K mutations <input type="checkbox"/> The patient has lymph node involvement, following complete resection <input type="checkbox"/> The patient's disease is unresectable or metastatic <input type="checkbox"/> The requested medication will be used as monotherapy <input type="checkbox"/> None of the above	
Q8. Will the requested medication be used in combination with dabrafenib (Tafinlar)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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.

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have documented BRAF V600E or V600K mutation as detected by a FDA-approved test?
Q6. Will the requested medication be used in combination with encorafenib (Braftovi)?
Q7. Is the patient 18 years of age or older?
Q8. Is the requested medication prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

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

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Methylphenidates-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD) <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For NARCOLEPSY, please select all that apply: <input type="checkbox"/> The diagnosis was confirmed by a sleep study <input type="checkbox"/> A sleep study would not be feasible <input type="checkbox"/> None of the above
Q6. If a sleep study is not feasible, please provide justification:
Q7. Does the patient have any of the following? (Please select all that apply.)



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Methylphenidates-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Miglustat-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Gaucher disease, type 1 (mild to moderate) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient a candidate for enzyme replacement therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Miglustat-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Multiple Sclerosis-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the medication that is being requested: <input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron <input type="checkbox"/> Copaxone/Glatiramer <input type="checkbox"/> Gilenya <input type="checkbox"/> Tecfidera/Dimethyl Fumarate
Q4. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Relapsing forms of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS) <input type="checkbox"/> First clinical episode and the patient has MRI features consistent with multiple sclerosis <input type="checkbox"/> Other
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. Please indicate the patient's age:



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Multiple Sclerosis-1 Medicare

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

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

Patient Name:	Prescriber Name:
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- Less than 10 years of age
- 10 to 17 years of age
- 18 years of age or older

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

- Yes No

Q8. For GILENYA, please select all that apply to the patient:

- Recent (within the last 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure
- History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless the patient has a pacemaker
- Baseline QTc interval greater than or equal to 500 milliseconds
- Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (such as quinidine, procainamide, amiodarone, or sotalol)
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Natpara-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Will the requested medication be used to control hypocalcemia?
Q6. Is the patient 18 years of age or older?

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Natpara-1 Medicare

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

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

Patient Name:

Prescriber Name:

hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



COVERAGE DETERMINATION REQUEST FORM

EOC ID: Nerlynx-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select all that apply to the patient:
Q6. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nerlynx-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nexavar-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Advanced renal cell carcinoma <input type="checkbox"/> Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma <input type="checkbox"/> Unresectable hepatocellular carcinoma <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For DIFFERENTIATED THYROID CARCINOMA, is the disease refractory to radioactive iodine treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Does the patient have squamous cell lung cancer being treated with carboplatin and paclitaxel? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

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Nexavar-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ninlaro-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below.
Q5. Will the requested medication be used in combination with lenalidomide (Revlimid) and dexamethasone?
Q6. Does the patient have a history of at least one prior therapy?
Q7. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ninlaro-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Neurogenic orthostatic hypotension (NOH) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient symptomatic?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient's diagnosis caused by one of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> Primary autonomic failure (for example, Parkinson's disease, multiple system atrophy, pure autonomic failure)</p> <p><input type="checkbox"/> Dopamine beta-hydroxylase deficiency</p> <p><input type="checkbox"/> Non-diabetic autonomic neuropathy</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-2 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nubeqa-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-metastatic, castration-resistant prostate cancer <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the requested medication prescribed by or in consultation with an oncologist or urologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nubeqa-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Severe asthma with eosinophilic phenotype <input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis (EGPA) <input type="checkbox"/> Hypereosinophilic syndrome <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. FOR HYPEREOSINOPHILIC SYNDROME, has the condition lasted at least 6 months without an identifiable non-hematologic secondary cause? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 6 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with any of the following?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-1 Medicare

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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:

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuedexta-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Pseudobulbar affect (PBA) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the requested medication prescribed by or in consultation with a neurologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Does the patient have any of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> History of prolonged QT interval, congenital long QT syndrome or Torsades de pointes</p> <p><input type="checkbox"/> Heart failure</p> <p><input type="checkbox"/> Complete AV block without an implanted pacemaker or high risk of complete AV block</p> <p><input type="checkbox"/> Concomitant use with quinidine, quinine, mefloquine, or drugs that prolong QT interval and are metabolized by</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuedexta-1 Medicare

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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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuplazid-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Parkinson's disease psychosis <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient experiencing hallucinations and/or delusions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuplazid-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Octreotide-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Acromegaly <input type="checkbox"/> Metastatic carcinoid syndrome <input type="checkbox"/> Vasoactive intestinal peptide-secreting tumor (VIPoma) with associated diarrhea <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For ACROMEGALY, has the patient had an inadequate response to or is ineligible for any of the following (please select all that apply)? <input type="checkbox"/> Surgery <input type="checkbox"/> Radiation <input type="checkbox"/> Bromocriptine mesylate <input type="checkbox"/> None of the above
Q6. If the patient has NOT tried any of the options listed in the previous question, is there a reason these options cannot be used (i.e., contraindication, history of adverse event, patient is not a candidate, etc.)?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Octreotide-1 Medicare

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

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

Patient Name:	Prescriber Name:
----------------------	-------------------------

Q7. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Odomzo-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select any of the following that applies to the patient:
Q6. Is the patient 18 years of age or older?
Q7. Is the patient pregnant?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Odomzo-1 Medicare

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

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

Patient Name:

Prescriber Name:

Not applicable - the patient is not of child-bearing potential

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Onureg-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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.

Seven question blocks (Q1-Q7) regarding therapy type, start date, diagnosis, maintenance treatment, and patient ability to complete therapy.



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Onureg-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opsumit-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Was the diagnosis confirmed by right heart catheterization or doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e. g., patient is frail, elderly, etc.)?
Q6. Is the patient 18 years of age or older?
Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opsumit-1 Medicare

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

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

Patient Name:

Prescriber Name:

Q8. Is the patient pregnant?

Yes

No

Not applicable

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orilissa-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Moderate to severe pain associated with endometriosis <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Known osteoporosis</p> <p><input type="checkbox"/> Severe hepatic impairment</p> <p><input type="checkbox"/> Concurrent use of strong organic anion transporting polypeptide (OATP) 1B1 inhibitors</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orilissa-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orkambi-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have documented homozygous F508del mutation as confirmed by a FDA-approved CF mutation test?
Q6. Is the medication prescribed by, or in consultation with, a pulmonologist or prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orkambi-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Osphena-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause</p> <p><input type="checkbox"/> Moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Undiagnosed abnormal genital bleeding</p> <p><input type="checkbox"/> Known or suspected estrogen-dependent neoplasia</p> <p><input type="checkbox"/> Active deep vein thrombosis (DVT), pulmonary embolism (PE), or a history of these conditions</p> <p><input type="checkbox"/> Active arterial thromboembolic disease (eg. stroke, myocardial infarction) or a history of these conditions</p> <p><input type="checkbox"/> Pregnancy</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Osphena-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> None of the above	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Oxandrolone-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Bone pain associated with osteoporosis</p> <p><input type="checkbox"/> Protein catabolism associated with chronic corticosteroid administration</p> <p><input type="checkbox"/> Adjunctive therapy to promote weight gain</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. FOR ADJUNCTIVE THERAPY TO PROMOTE WEIGHT GAIN: Is the requested medication being used after weight loss associated with one of the following?</p> <p><input type="checkbox"/> Extensive surgery</p> <p><input type="checkbox"/> Chronic infections</p> <p><input type="checkbox"/> Severe trauma</p> <p><input type="checkbox"/> Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Oxandrolone-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

- Known or suspected carcinoma of the prostate or breast in males
- Carcinoma of the breast in females with hypercalcemia
- Pregnancy
- Nephrosis or nephrotic phase of nephritis
- Hypercalcemia
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
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? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> AIDS-related Kaposi's sarcoma <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Do any of the following apply to this patient (please select all that apply)? <input type="checkbox"/> The requested medication is being used to treat cutaneous lesions <input type="checkbox"/> 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) <input type="checkbox"/> None of the above
Q6. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

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:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the requested medication being prescribed by or in consultation with an oncologist or HIV specialist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pegylated Interferon-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic hepatitis B infection <input type="checkbox"/> Chronic hepatitis C <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the requested medication prescribed by, or in consultation with, any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious disease specialist <input type="checkbox"/> None of the above</p>
<p>Q6. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pegylated Interferon-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Uncontrolled depression <input type="checkbox"/> None of the above	
Q7. For HEPATITIS C: Please provide the patient's genotype below:	
Q8. For HEPATITIS C: Please provide the patient's initial HCV RNA level and, if continuing therapy, the current HCV RNA level and week of treatment:	
Q9. For HEPATITIS C: Will the requested medication be used in conjunction with Sovaldi? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. For HEPATITIS C: Is the patient treatment-naive or experienced? <input type="checkbox"/> Treatment naive (i.e., has never been treated for hepatitis C) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Does the patient have compensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pemazyre-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have confirmed fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by a FDA-approved test?
Q6. Has the patient been previously treated?
Q7. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pemazyre-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Piqray-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Breast cancer, advanced or metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient's disease hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient's cancer PIK3CA-mutated?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Please select all that apply to this patient:</p> <p><input type="checkbox"/> The patient is male or postmenopausal</p> <p><input type="checkbox"/> The requested medication will be used in combination with fulvestrant</p> <p><input type="checkbox"/> The patient's disease has progressed on or after an endocrine-based regimen</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Piqray-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> None of the above	
Q8. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested medication prescribed by or in consultation with an oncologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pomalyst-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Kaposi's sarcoma, AIDS-related <input type="checkbox"/> Kaposi's sarcoma in a HIV-negative adult <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below.
Q5. FOR AIDS-RELATED KAPOSII'S SARCOMA, has the patient failed highly active antiretroviral therapy (HAART)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. FOR MULTIPLE MYELOMA, please select all that apply to this patient: <input type="checkbox"/> The requested medication will be used in combination with dexamethasone in an adult patient <input type="checkbox"/> The patient has received at least 2 prior therapies (including lenalidomide and a proteasome inhibitor) <input type="checkbox"/> The patient has demonstrated disease progression on or within 60 days of completion of the last therapy <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pomalyst-1 Medicare

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

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

Patient Name:

Prescriber Name:

Q7. Is the patient pregnant?

- Yes
- No
- Not applicable - the patient is not of child-bearing potential

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Promacta-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic idiopathic thrombocytopenic purpura (ITP)</p> <p><input type="checkbox"/> Chronic hepatitis C infection associated thrombocytopenia</p> <p><input type="checkbox"/> Severe aplastic anemia</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For APLASTIC ANEMIA, please select any of the following that apply to the patient:</p> <p><input type="checkbox"/> The patient had an insufficient response to immunosuppressive therapy</p> <p><input type="checkbox"/> The requested medication will be used in combination with standard immunosuppressive therapy</p> <p><input type="checkbox"/> None of the above</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Promacta-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pulmonary Fibrosis-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate which medication this request is for:</p> <p><input type="checkbox"/> Esbriet <input type="checkbox"/> Ofev</p>
<p>Q4. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic fibrosing interstitial lung disease with a progressive phenotype</p> <p><input type="checkbox"/> Idiopathic pulmonary fibrosis (IPF)</p> <p><input type="checkbox"/> Systemic sclerosis-associated interstitial lung disease (ILD)</p> <p><input type="checkbox"/> Other</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Is the requested medication prescribed by or in consultation with a pulmonologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pulmonary Fibrosis-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Qinlock-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Gastrointestinal stromal tumor (GIST), advanced <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient received prior treatment with 3 or more kinase inhibitors, including imatinib (Gleevec)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. If the patient has NOT tried 3 or more kinase inhibitors, including imatinib (Gleevec), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?
Q7. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Qinlock-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Regranex-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication below: <input type="checkbox"/> Lower extremity diabetic neuropathic ulcer <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the ulcer extend into the subcutaneous tissue or beyond and have an adequate blood supply? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 16 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Does the patient have a known neoplasm at the site of application? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Regranex-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Repatha-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Primary hyperlipidemia (hypercholesterolemia) including heterozygous familial hypercholesterolemia (HeFH)</p> <p><input type="checkbox"/> Homozygous familial hypercholesterolemia</p> <p><input type="checkbox"/> Required prophylaxis of myocardial infarction, stroke, or coronary revascularization in a patient with established cardiovascular disease</p> <p><input type="checkbox"/> Clinical atherosclerotic cardiovascular disease (CVD)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. FOR CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, has the patient experienced any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Acute coronary syndrome</p> <p><input type="checkbox"/> History of myocardial infarction</p> <p><input type="checkbox"/> Stable or unstable angina</p> <p><input type="checkbox"/> Coronary or other arterial revascularization</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Repatha-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Stroke <input type="checkbox"/> Transient ischemic stroke (TIA) <input type="checkbox"/> Peripheral arterial disease (PAD) presumed to be atherosclerotic region <input type="checkbox"/> None of the above	
Q6. Is the patient 13 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Retevmo-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Medullary thyroid cancer (MTC), advanced or metastatic, RET-mutant</p> <p><input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic, RET fusion-positive</p> <p><input type="checkbox"/> Thyroid cancer, advanced or metastatic, RET fusion-positive</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient requires systemic therapy (such as the requested medication)</p> <p><input type="checkbox"/> The patient is refractory to radioactive iodine, if appropriate</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the requested medication prescribed by or in consultation with an oncologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Retevmo-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revlimid-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For MULTIPLE MYELOMA, please indicate how the requested medication will be used in this patient:
Q6. For TRANSFUSION-DEPENDENT ANEMIA DUE TO MDS, is the condition associated with a deletion 5q



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revlimid-1 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. For MANTLE CELL LYMPHOMA, has the patient relapsed or progressed after two (2) prior therapies (one of which included bortezomib)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For FOLLICULAR LYMPHOMA OR MARGINAL ZONE LYMPHOMA, will the requested medication be used in combination with rituximab? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable - the patient is not of child-bearing potential	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic graft-vs-host disease in adult and pediatric patients <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient failed at least 2 prior lines of systemic therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient has NOT tried at least 2 prior lines of systemic therapy, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?</p>



COVERAGE DETERMINATION REQUEST FORM

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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rozlytrek-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> ROS1-positive metastatic non-small cell lung cancer (NSCLC)</p> <p><input type="checkbox"/> Solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below.</p>
<p>Q5. For SOLID TUMORS, please select all that apply to this patient:</p> <p><input type="checkbox"/> The patient's tumors are metastatic or where surgical resection is likely to result in severe morbidity</p> <p><input type="checkbox"/> The patient's tumors have either progressed following treatment or have no satisfactory alternative therapy</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 12 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rozlytrek-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rubraca-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer</p> <p><input type="checkbox"/> Epithelial ovarian, fallopian tube, or primary peritoneal cancer</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has deleterious BRCA mutation (germline and/or somatic) as detected by a FDA-approved test</p> <p><input type="checkbox"/> The patient has been treated with two or more prior lines of chemotherapy</p> <p><input type="checkbox"/> The disease is recurrent</p> <p><input type="checkbox"/> The requested medication will be used as maintenance treatment</p> <p><input type="checkbox"/> The patient is in complete or partial response to platinum-based chemotherapy</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rubraca-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q6. For PROSTATE CANCER, has the patient been treated with androgen receptor-directed therapy and a taxane-based chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the requested medication prescribed by or in consultation with an oncologist or hematologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rydapt-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For ACUTE MYELOGENOUS LEUKEMIA, please select all that apply to the patient:
Q6. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rydapt-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the requested medication being prescribed by or in consultation with an oncologist or hematologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Samsca-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Clinically significant hypervolemic or euvolemic hyponatremia, including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient's serum sodium less than 125 mEq/L or less with marked hyponatremia that is symptomatic and has resisted correction with fluid restriction? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Does the patient have any of the following (please select all that apply)? <input type="checkbox"/> Anuria



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Samsca-1 Medicare

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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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Signifor-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Cushing's disease <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient had an inadequate response to or is not a candidate for surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. FOR RENEWAL: Is there documentation of a clinically meaningful reduction in 24-hour urinary free cortisol (UFC) levels or improvement in signs or symptoms of the disease? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Signifor-1 Medicare

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

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Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sildenafil-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Pulmonary arterial hypertension (WHO Group I) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Was the patient's diagnosis confirmed by right heart catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Is the patient currently receiving nitrate therapy (includes intermittent use)?</p>



COVERAGE DETERMINATION REQUEST FORM

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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:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somatuline Depot-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Acromegaly <input type="checkbox"/> Carcinoid syndrome <input type="checkbox"/> Gastroenteropancreatic neuroendocrine tumors (GEP-NETs), Unresectable, well or moderately differentiated, locally advanced or metastatic <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For ACROMEGALY, please select any of the following that applies to the patient: <input type="checkbox"/> Patient has had an inadequate response to surgery and/or radiotherapy <input type="checkbox"/> Patient is not a candidate for surgery and/or radiotherapy <input type="checkbox"/> None of the above
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Somatuline Depot-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somavert-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Acromegaly <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient had an inadequate response to or is ineligible for surgery or radiation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Was the requested medication prescribed by or in consultation with an endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somavert-1 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sprycel-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL)</p> <p><input type="checkbox"/> Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below.</p>
<p>Q5. For ACUTE LYMPHOBLASTIC LEUKEMIA, please select any of the following that apply to the patient:</p> <p><input type="checkbox"/> Patient had resistance or intolerance to prior therapy</p> <p><input type="checkbox"/> Disease is newly diagnosed and the requested medication will be used in combination with chemotherapy</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. For CHRONIC MYELOGENOUS LEUKEMIA, please select any of the following that apply to the patient:</p> <p><input type="checkbox"/> Disease is newly diagnosed in the chronic phase</p> <p><input type="checkbox"/> Disease is chronic, accelerated, or myeloid or lymphoid blast phase with resistance or intolerance to prior therapy</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sprycel-1 Medicare

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

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Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stelara-3 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Crohn's disease, moderate to severely active</p> <p><input type="checkbox"/> Plaque psoriasis, moderate to severe</p> <p><input type="checkbox"/> Psoriatic arthritis, active</p> <p><input type="checkbox"/> Ulcerative colitis, moderate to severely active</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient had a trial and failure or intolerance or contraindication to any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Enbrel <input type="checkbox"/> Humira <input type="checkbox"/> None of the above</p>
<p>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.)?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stelara-3 Medicare

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

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

Patient Name:

Prescriber Name:

Q7. Has the patient been screened for latent tuberculosis infection prior to initiation of treatment?

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication below:</p> <p><input type="checkbox"/> Colorectal cancer, metastatic</p> <p><input type="checkbox"/> Gastrointestinal stromal tumor (GIST), locally advanced, unresectable or metastatic</p> <p><input type="checkbox"/> Liver carcinoma</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For COLORECTAL CANCER, is the patient RAS wild type ?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For COLORECTAL CANCER, has the patient been previously treated with any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy</p> <p><input type="checkbox"/> Anti-VEGF therapy</p> <p><input type="checkbox"/> Anti-EGFR therapy</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-1 Medicare

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

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

Patient Name:		Prescriber Name:	
<input type="checkbox"/> 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)?			
<input type="checkbox"/> Imatinib (Gleevec)		<input type="checkbox"/> Sunitinib (Sutent)	<input type="checkbox"/> None of the above
Q9. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?			
Q10. For LIVER CARCINOMA, has the patient been previously treated with sorafenib (Nexavar)?			
<input type="checkbox"/> Yes		<input type="checkbox"/> 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?			
<input type="checkbox"/> Yes		<input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sunosi-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Narcolepsy <input type="checkbox"/> Obstructive sleep apnea (OSA) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have excessive daytime drowsiness?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have a trial of or contraindication to any of the following? (Please select all that apply.)</p> <p><input type="checkbox"/> Armodafinil <input type="checkbox"/> Modafinil <input type="checkbox"/> None of the above</p>
<p>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.)?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sunosi-1 Medicare

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

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

Patient Name:	Prescriber Name:
----------------------	-------------------------

Q8. Is the patient 18 years old or older?

Yes

No

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

Concomitant use of a monoamine oxidase inhibitor (MAOI)

Use within 14 days of discontinuing a monoamine oxidase inhibitor (MAOI)

None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sutent-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> Gastrointestinal stromal tumor</p> <p><input type="checkbox"/> Pancreatic neuroendocrine tumors, unresectable locally advanced or metastatic</p> <p><input type="checkbox"/> Renal cell carcinoma</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For GASTROINTESTINAL STROMAL TUMOR, has the patient had disease progression on or an intolerance to imatinib (Gleevec)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient has NOT tried imatinib (Gleevec), is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?</p>
<p>Q7. For RENAL CELL CARCINOMA, please select all that apply to the patient:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sutent-1 Medicare

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

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Patient Name:	Prescriber Name:
----------------------	-------------------------

<input type="checkbox"/> The disease is advanced <input type="checkbox"/> The requested medication will be used as adjuvant therapy following nephrectomy in a patient who is at high risk for recurrence <input type="checkbox"/> None of the above
--

Q8. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symdeko-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Cystic fibrosis (CF) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select if any of the following apply to this patient:</p> <p><input type="checkbox"/> The patient is homozygous for the F508del mutation</p> <p><input type="checkbox"/> Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-cleared CF mutation test</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 6 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication being prescribed by or in consultation with a pulmonologist or a prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symdeko-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symlin-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Diabetes mellitus (type 1 or type 2) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER please specify below:</p>
<p>Q5. Does the patient use mealtime insulin therapy and has failed to achieve desired glucose control?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Confirmed diagnosis of gastroparesis</p> <p><input type="checkbox"/> Hypoglycemia unawareness</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symlin-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tabrecta-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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.

Seven question blocks (Q1-Q7) regarding therapy type, start date, diagnosis, MET mutation, age, and prescriber information.



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tabrecta-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tafinlar-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Anaplastic thyroid carcinoma, locally advanced or metastatic</p> <p><input type="checkbox"/> Malignant melanoma, unresectable or metastatic</p> <p><input type="checkbox"/> Non-small cell lung cancer, metastatic</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For ANAPLASTIC THYROID CARCINOMA, please select all that apply to the patient:</p> <p><input type="checkbox"/> Patient has BRAF V600E mutation</p> <p><input type="checkbox"/> The requested medication will be used in combination with trametinib (Mekinist)</p> <p><input type="checkbox"/> Patient has no satisfactory locoregional treatment options</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. For NON-SMALL CELL LUNG CANCER, please select all that apply to the patient:</p> <p><input type="checkbox"/> Patient has BRAF V600E mutation</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tafinlar-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> The requested medication will be used in combination with trametinib (Mekinist)	
<input type="checkbox"/> Patient was previously treated as monotherapy	
<input type="checkbox"/> None of the above	
Q7. For MELANOMA, does the patient have a BRAF V600E or V600K mutation?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested medication prescribed by or in consultation with an oncologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tagrisso-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has EGFR exon 19 deletion or exon 21 L858R mutation</p> <p><input type="checkbox"/> The requested medication is being used as first-line therapy</p> <p><input type="checkbox"/> There is confirmed presence of T790M EGFR mutation</p> <p><input type="checkbox"/> The patient's disease has progressed on or after EGFR tyrosine kinase inhibitor therapy</p> <p><input type="checkbox"/> The patient's diagnosis was confirmed by a FDA-approved test</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tagrisso-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Takhzyro-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Hereditary angioedema (HAE) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Will the requested medication be used in the prevention of angioedema attacks? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Does the patient have a trial of or contraindication to Firazyr? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. If the patient has NOT tried Firazyr, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?
Q8. Is the patient 12 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Takhzyro-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested medication being prescribed by or in consultation with a hematologist, immunologist, or allergist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Talzenna-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Breast cancer, locally advanced or metastatic <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have a deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient's disease human epidermal growth factor receptor 2 (HER2)-negative? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the requested medication prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Talzena-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Targretin Gel-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Primary cutaneous T-cell lymphoma (CTCL Stage 1A/1B) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient had an inadequate response, intolerance, or contraindication to at least one prior systemic therapy (e.g., corticosteroids) indicated for cutaneous manifestations of CTCL? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. If the patient has NOT tried one prior systemic therapy (e.g. corticosteroids), is there a reason why it cannot be used (i.e., contraindication, history of adverse event, etc.)?
Q7. Is the requested medication being prescribed by or in consultation with an oncologist or dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Targretin Gel-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tasigna-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: * <input type="checkbox"/> Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in chronic phase <input type="checkbox"/> Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in accelerated phase <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select any of the following that applies to the patient: <input type="checkbox"/> The patient is newly diagnosed <input type="checkbox"/> The patient is resistant or intolerant to prior therapy that included imatinib <input type="checkbox"/> The patient is resistant or intolerant to prior tyrosine kinase inhibitor therapy <input type="checkbox"/> None of the above
Q6. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tasigna-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

- Long QT syndrome
- Uncorrected hypokalemia
- Uncorrected hypomagnesemia
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tazverik-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Epithelioid sarcoma, metastatic or locally advanced</p> <p><input type="checkbox"/> Follicular lymphoma, relapsed or refractory</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For EPITHELIOID SARCOMA, is the patient eligible for complete resection?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For FOLLICULAR LYMPHOMA, please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has tumors that are positive for an EZH2 mutation as detected by a FDA-approved test</p> <p><input type="checkbox"/> The patient has received at least 2 prior systemic therapies</p> <p><input type="checkbox"/> The patient has no satisfactory alternative treatment options</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tazverik-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the patient 16 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tegsedi-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Polyneuropathy of hereditary transthyretin-mediated amyloidosis <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Platelet count less than 100,000 per microliter</p> <p><input type="checkbox"/> Urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher</p> <p><input type="checkbox"/> None of the above</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tegsedi-2 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID: Tepmetko-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have mesenchymal-epithelial transition (MET) exon 14 skipping alterations?
Q6. Is the patient 18 years of age or older?
Q7. Is the requested medication being prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tepmetko-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Teriparatide-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Osteoporosis due to associated sustained systemic glucocorticoid therapy <input type="checkbox"/> Postmenopausal osteoporosis <input type="checkbox"/> Primary or hypogonadal osteoporosis in a male patient <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have a previous trial and failure, contraindication, or intolerance to a bisphosphonate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. For POSTMENOPAUSAL OSTEOPOROSIS, does the patient have a history of or contraindication to Tymlos? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. If the patient has NOT tried any of the medication(s) listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Teriparatide-1 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Has the patient received more than 24 months of treatment with the requested medication?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tetrabenazine-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chorea associated with Huntington's disease <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Actively suicidal</p> <p><input type="checkbox"/> Untreated or inadequately treated depression</p> <p><input type="checkbox"/> Impaired hepatic function</p> <p><input type="checkbox"/> Concomitant use of monoamine oxidase inhibitors</p> <p><input type="checkbox"/> Concomitant use of reserpine or within 20 days of discontinuing reserpine</p> <p><input type="checkbox"/> None of the above</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tetrabenazine-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Thalomid-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Multiple myeloma, newly diagnosed <input type="checkbox"/> Erythema nodosum leprosum (ENL) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the requested medication being prescribed by or in consultation with an oncologist or infectious disease specialist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable - patient is not of child-bearing potential</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Thalomid-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tibsovo-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Acute myeloid leukemia <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select all that apply to the patient:</p> <p><input type="checkbox"/> The disease is relapsed or refractory</p> <p><input type="checkbox"/> The patient is newly diagnosed</p> <p><input type="checkbox"/> The patient has a susceptible isocitrate dehydrogenase-1 mutation as detected by an FDA-approved test</p> <p><input type="checkbox"/> The patient is 75 years of age or older</p> <p><input type="checkbox"/> The patient has comorbidities that preclude use of intensive induction chemotherapy</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tibsovo-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trientine-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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.

Five question boxes (Q1-Q5) regarding therapy type, start date, diagnosis, and intolerance to penicillamine.

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trikafta-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene verified by an FDA-cleared CF mutation test?
Q6. Is the patient 12 years of age or older?
Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or a prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Trikafta-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Cholangiocarcinoma, unresectable locally advanced or metastatic <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Has the patient been previously treated? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

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 consultation with an oncologist, gastroenterologist, or hepatologist?

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tukysa-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Breast cancer, advanced unresectable or metastatic (including brain metastases) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please select all that apply to the patient:</p> <p><input type="checkbox"/> The patient has HER2-positive breast cancer</p> <p><input type="checkbox"/> The patient has received one or more prior anti-HER2-based regimens in the metastatic setting</p> <p><input type="checkbox"/> The requested medication is being used in combination with trastuzumab (Herceptin) and capecitabine (Xeloda)</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by or in consultation with an oncologist?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tukysa-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Turalio-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select if any of the following apply to this patient:
Q6. Is the patient 18 years of age or older?
Q7. Is the requested medication prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Turalio-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tymlos-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient had an osteoporotic fracture or has multiple risk factors for fracture?
Q6. Has the patient had a previous trial of or contraindication to a bisphosphonate?
Q7. If the patient has NOT tried a bisphosphonate, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?
Q8. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tymlos-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Has treatment duration with the requested medication exceeded 24 months in the patient's lifetime?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ukoniq-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Marginal zone lymphoma (MZL), relapsed or refractory</p> <p><input type="checkbox"/> Follicular lymphoma (FL), relapsed or refractory</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For MARGINAL ZONE LYMPHOMA, has the patient received at least one prior anti-CD20-based regimen?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.)?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ukoniq-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. For FOLLICULAR LYMPHOMA, has the patient received at least three prior lines of systemic therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Upravi-3 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Pulmonary arterial hypertension (PAH), WHO Group I <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient's diagnosis been confirmed by right heart catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the patient receiving the requested medication concomitantly with strong CYP2C8 inhibitors (e.g.,



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Uptravi-3 Medicare

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

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

Patient Name:	Prescriber Name:
gemfibrozil)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Venclexta-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic lymphocytic leukemia (CLL) <input type="checkbox"/> Small lymphocytic lymphoma (SLL) <input type="checkbox"/> Acute myeloid leukemia (AML) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For ACUTE MYELOID LEUKEMIA, please select all that apply to this patient:</p> <p><input type="checkbox"/> The patient's disease is newly-diagnosed <input type="checkbox"/> The requested medication will be used in combination with azacitidine, decitabine or low-dose cytarabine <input type="checkbox"/> The patient is 75 years of age or older <input type="checkbox"/> The patient has comorbidities that preclude the use of intensive induction chemotherapy <input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

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Venclexta-1 Medicare

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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with an oncologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verquvo-3 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Chronic heart failure (HF), NYHA Class II to IV <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have a left ventricular ejection fraction less than 45%? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Has the patient had a previous hospitalization for heart failure (HF) within 6 months or outpatient IV diuretic treatment for HF within 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verquvo-3 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the requested medication prescribed by or in consultation with a cardiologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient using the requested medication concomitantly with other soluble guanylate cyclase (sGC) stimulators?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verzenio-1 Medicare

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Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

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Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select all that apply to the patient:
List of conditions and treatments with checkboxes.



COVERAGE DETERMINATION REQUEST FORM

EOC ID: Vitrakvi-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select all that apply to this patient:
Q6. Is the requested medication being prescribed by or in consultation with an oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vitakvi-1 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vizimpro-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Non-small cell lung cancer, metastatic <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have confirmed epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by a FDA-approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vizimpro-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Voriconazole-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> Invasive aspergillosis</p> <p><input type="checkbox"/> Candidemia</p> <p><input type="checkbox"/> Esophageal candidiasis</p> <p><input type="checkbox"/> Invasive candidiasis of the skin and infections in abdomen, kidney, bladder wall, and wounds</p> <p><input type="checkbox"/> Serious fungal infections due to Scedosporium apiospermum or Fusarium species</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Please indicate the route of administration:</p> <p><input type="checkbox"/> Oral <input type="checkbox"/> IV</p>
<p>Q6. Is the requested medication prescribed by or in consultation with an infectious disease specialist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Voriconazole-2 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Does the patient reside in a long term care (LTC) or hospital setting? (NOTE: B vs D questions only apply to the IV dose forms)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the medication being given via an infusion pump? (NOTE: B vs D questions only apply to the IV dose forms)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Did Medicare pay for the infusion pump? (NOTE: B vs D questions only apply to the IV dose forms)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Votrient-1 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. What is the patient's diagnosis for the requested medication? <input type="checkbox"/> Renal cell carcinoma, advanced <input type="checkbox"/> Soft tissue sarcoma, advanced <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For SOFT TISSUE SARCOMA, has the patient received at least one prior chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Votrient-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vyndamax-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Transthyretin related familial amyloid cardiomyopathy (wild type or hereditary) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the requested medication prescribed by or in consultation with a cardiologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vyndamax-1 Medicare

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

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COVERAGE DETERMINATION REQUEST FORM

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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Von Hippel-Lindau (VHL) disease <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient require therapy for any of the following conditions that do not require immediate surgery?</p> <p><input type="checkbox"/> Renal cell carcinoma (RCC)</p> <p><input type="checkbox"/> Central nervous system (CNS) hemangioblastomas</p> <p><input type="checkbox"/> Pancreatic neuroendocrine tumors (pNET)</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Is the patient 18 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Welireg-1 Medicare

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

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Patient Name:	Prescriber Name:
----------------------	-------------------------

Yes

No

Q7. Is the patient pregnant?

Yes

No

Not applicable - the patient is not of child-bearing potential

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xalkori-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive or ROS1-positive as detected by a FDA-approved test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by, or in consultation with, an oncologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xalkori-1 Medicare

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

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Prescriber Name:

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xeljanz-4 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Psoriatic arthritis, active <input type="checkbox"/> Rheumatoid arthritis, moderate to severe <input type="checkbox"/> Ulcerative colitis, moderate to severe <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient had failure, contraindication, or intolerance to any of the following? (please select all that apply):</p> <p><input type="checkbox"/> Enbrel (etanercept) <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> None of the above</p>
<p>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)?</p>
<p>Q7. Will the patient be screened for latent tuberculosis infection prior to initiation of treatment?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xeljanz-4 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xgeva-2 Medicare

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

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

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Bone metastases from a solid tumor <input type="checkbox"/> Giant cell tumor of the bone <input type="checkbox"/> Hypercalcemia of malignancy <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For GIANT CELL TUMOR OF THE BONE, is the patient's disease unresectable or surgical resection is likely to result in severe morbidity? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. For HYPERCALCEMIA OF MALIGNANCY, is the patient's disease refractory to bisphosphonate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xgeva-2 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Not applicable - the patient has not tried bisphosphonates	
Q7. If the patient has NOT tried bisphosphonate therapy, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?	
Q8. Is the medication to be used for the prevention of skeletal-related events? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Q9. Does the patient have hypocalcemia (calcium less than 8.0 mg/dL)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xolair-2 Medicare

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

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chronic idiopathic urticaria <input type="checkbox"/> Moderate to severe persistent asthma <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below.</p>
<p>Q5. For URTICARIA, does the patient remain symptomatic despite H1 antihistamine therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable - the patient has not tried H1 antihistamine therapy</p>
<p>Q6. If the patient has NOT tried H1 antihistamine therapy, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?</p>



COVERAGE DETERMINATION REQUEST FORM

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Xolair-2 Medicare

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Patient Name:	Prescriber Name:
Q7. For ASTHMA, please select all that apply to the patient: <input type="checkbox"/> The patient has a positive skin test or in vitro reactivity to a perennial aeroallergen <input type="checkbox"/> The patient's symptoms are inadequately controlled with inhaled corticosteroids <input type="checkbox"/> None of the above	
Q8. FOR NASAL POLYPS, has the patient had an inadequate response to nasal corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. If the patient has NOT tried nasal corticosteroids, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?	
Q10. Is the patient 6 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is the requested medication prescribed by or in consultation with an allergist, dermatologist, immunologist, otolaryngologist, or pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xospata-2 Medicare

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

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Acute myeloid leukemia, relapsed or refractory <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have a presence of an FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xospata-2 Medicare

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xpovio-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Diffuse large B-cell lymphoma, relapsed or refractory (DLBCL, including from follicular lymphoma)</p> <p><input type="checkbox"/> Multiple myeloma, relapsed or refractory</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. For DIFFUSE LARGE B-CELL LYMPHOMA, has the patient received at least 2 lines of systemic therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For MULTIPLE MYELOMA, will the requested medication be used in combination with dexamethasone?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. For MULTIPLE MYELOMA, has the patient received at least 4 prior therapies?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

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Xpovio-1 Medicare

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Patient Name:

Prescriber Name:

Q8. For MULTIPLE MYELOMA, is the patient's disease refractory to any of the following? (Please select all that apply)

- At least two proteasome inhibitors
- At least two immunomodulatory agents
- An anti-CD38 monoclonal antibody
- None of the above

Q9. If the patient has NOT tried any of the medications listed in the previous question(s), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q10. Is the patient 18 years of age or older?

- Yes No

Q11. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?

- Yes No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-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 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.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Prostate cancer (castration-resistant)</p> <p><input type="checkbox"/> Prostate cancer (metastatic, castration-sensitive)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the requested medication prescribed by (or in consultation with) an oncologist or urologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-1 Medicare

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

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Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xuriden-1 Medicare

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

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Hereditary orotic aciduria <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Narcolepsy with cataplexy <input type="checkbox"/> Narcolepsy with excessive daytime drowsiness <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. FOR NARCOLEPSY WITH EXCESSIVE DAYTIME DROWSINESS: Does the patient have a trial of or contraindication to any of the following? (Please select all that apply)</p> <p><input type="checkbox"/> Modafinil <input type="checkbox"/> Armodafinil <input type="checkbox"/> None of the above</p>
<p>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.)?</p>
<p>Q7. Is the patient 7 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-1 Medicare

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

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

Patient Name:	Prescriber Name:
----------------------	-------------------------

Yes

No

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

- Concomitant treatment with sedative hypnotic agents
- Succinic semialdehyde dehydrogenase deficiency
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xywav-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Narcolepsy with cataplexy <input type="checkbox"/> Narcolepsy with excessive daytime drowsiness <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. FOR NARCOLEPSY WITH EXCESSIVE DAYTIME DROWSINESS: Does the patient have a trial of or contraindication to any of the following? (Please select all that apply)</p> <p><input type="checkbox"/> Modafinil <input type="checkbox"/> Armodafinil <input type="checkbox"/> None of the above</p>
<p>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.)?</p>
<p>Q7. Is the patient 7 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xywav-1 Medicare

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

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

Patient Name:	Prescriber Name:
----------------------	-------------------------

Yes

No

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

- Concomitant treatment with sedative hypnotic agents
- Succinic semialdehyde dehydrogenase deficiency
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Yonsa-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication below:
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the requested medication being used in combination with methylprednisolone?
Q6. Is the patient 18 years of age or older?
Q7. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?
Q8. Is the patient's partner pregnant?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Yonsa-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zarxio-1 Medicare

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

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

Form with two columns: Patient Name and Prescriber Name. Fields include Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, State Lic ID, and Specialty/facility name.

*Please note that Elixir will process the request as written, including drug name, with no substitution.

Expedited/Urgent checkbox

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?
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Advanced or recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer <input type="checkbox"/> Advanced ovarian, fallopian tube, or primary peritoneal cancer <input type="checkbox"/> Other
Q4. For ADVANCED OR RECURRENT EPITHELIAL OVARIAN CANCER, RECURRENT FALLOPIAN TUBE CANCER, OR RECURRENT PRIMARY PERITONEAL CANCER, please select all that apply to this patient: <input type="checkbox"/> The requested medication will be used as maintenance therapy <input type="checkbox"/> The patient is in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin) <input type="checkbox"/> None of the above
Q5. For ADVANCED OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, please select all that apply to this patient: <input type="checkbox"/> The patient has been treated with 3 or more prior chemotherapy regimens <input type="checkbox"/> The patient's cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA mutation, or genomic instability



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-2 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> The patient's disease has progressed more than 6 months after response to the last platinum-based chemotherapy <input type="checkbox"/> None of the above	
Q6. If the patient's diagnosis is OTHER, please specify below:	
Q7. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the requested medication prescribed by (or in consultation with) an oncologist or gynecologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ziextenzo-1 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Chemotherapy-induced febrile neutropenia (prophylaxis) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zykadia-2 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Elixir will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Non-small cell lung cancer (NSCLC), metastatic <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested medication prescribed by, or in consultation with, an oncologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zykadia-2 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	Date

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