



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Actimmune-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Chronic granulomatous disease</p> <p><input type="checkbox"/> Malignant osteoporosis (severe)</p> <p><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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Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adempas-2 Medicare

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

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

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

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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 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. For a diagnosis of CTEPH, please select all that apply:</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>Q5. For a diagnosis of PAH, was the diagnosis confirmed by right heart catheterization?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q7. If the patient is FEMALE, is she enrolled in the ADEMPAS REMS program?</p>



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A - the patient is not female	
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:
ADHD-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 Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. If the request is 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"/> Daytrana Patch <input type="checkbox"/> Dextroamphetamine ER <input type="checkbox"/> Dextroamphetamine IR <input type="checkbox"/> Methylphenidate <input type="checkbox"/> Vyvanse
Q4. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Attention deficit disorder (ADD) <input type="checkbox"/> Attention Deficit Hyperactivity disorder (ADHD) <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Other
Q5. For NARCOLEPSY, have sleep studies been completed which support the diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Patient Name:	Prescriber Name:
Q6. If the patient's diagnosis is OTHER, please specify below:	
Q7. Please indicate the patient's age below: <input type="checkbox"/> Under 3 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> 6 years or older	
Q8. Has the prescriber considered the benefits of use versus the potential risks of serious cardiovascular events? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Will the patient be using an MAOI concurrently with the requested medication, or within the last 14 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Is the prescriber a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alecensa-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Patient Name:

Prescriber Name:

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):	

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Alpha-1-antitrypsin (AAT) deficiency <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. Please select all that apply for this patient:</p> <p><input type="checkbox"/> The alpha1-proteinase inhibitor concentration is less than 11 micromoles per liter</p> <p><input type="checkbox"/> The patient's FEV1 level is between 35% and 60% predicted</p> <p><input type="checkbox"/> The patient's FEV1 level is greater than 60% predicted</p> <p><input type="checkbox"/> None of the above</p>
<p>Q7. IF THE FEV1 IS GREATER THAN 60% PREDICTED, has the patient experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment?</p>



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does the patient have IgA deficiency with antibodies against IgA?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alunbrig-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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. For NSCLC, is the patient anaplastic lymphoma kinase (ALK)-positive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. Has the patient experienced disease progression on (or is intolerant to) crizotinib (Xalkori)? <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 being prescribed by (or in consultation with) an oncologist?



COVERAGE DETERMINATION REQUEST FORM

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

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ampyra-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 Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Multiple sclerosis (MS) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has patient demonstrated sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra? <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 being 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)?



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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

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Analeptics-3 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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. Please indicate which medication this request is for: <input type="checkbox"/> Armodafinil <input type="checkbox"/> Modafinil
Q4. For MODAFINIL, is the patient 17 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Please indicate the patient's diagnosis for the requested medication: * <input type="checkbox"/> Excessive sleepiness associate with narcolepsy <input type="checkbox"/> Excessive sleepiness associated with shift work sleep disorder (SWSD) <input type="checkbox"/> Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSA/HS) <input type="checkbox"/> Other
Q6. For NARCOLEPSY, has the patient tried and failed (or had a contraindication or intolerance to) at least one other central nervous system stimulant (such as methylphenidate, mixed amphetamine salts, dextroamphetamine)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. For SWSD, please select all that apply to this patient:



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Patient Name:

Prescriber Name:

- The patient experiences excessive sleepiness frequently (5 times or more per month)
- The patient experiences excessive sleepiness while working
- None of the above

Q8. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arcalyst-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):

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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 specify the start date (MM/YY):
Q3. For CONTINUING THERAPY, has the patient's condition improved or stabilized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Cryopyrin-associated periodic syndrome (CAPS) <input type="checkbox"/> Other
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. Is the patient 12 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"/> Active infection <input type="checkbox"/> Chronic infection <input type="checkbox"/> Concurrent therapy with other biologics <input type="checkbox"/> None of the above



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Patient Name:

Prescriber Name:

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-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 Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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. Will Arikayce be used in combination with other antibacterial drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Has the patient been treated for 6 consecutive months with multidrug background regimen therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Has the patient achieved negative sputum cultures from prior treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-1 Medicare

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

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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested medication being prescribed by (or in consultation with) an infectious disease specialist or pulmonologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Atypical Antipsychotics-12 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Fanapt <input type="checkbox"/> Saphris <input type="checkbox"/> Vraylar</p>
<p>Q4. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Bipolar I disorder (manic or mixed episodes)</p> <p><input type="checkbox"/> Dementia-related psychosis only</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Other</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Please indicate the patient's age below:</p> <p><input type="checkbox"/> Under 10 years of age</p> <p><input type="checkbox"/> 10-17 years of age</p> <p><input type="checkbox"/> 18-64 years of age</p> <p><input type="checkbox"/> 65 years of age or older</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Atypical Antipsychotics-12 Medicare

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

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

Patient Name:

Prescriber Name:

Q7. Has the patient tried and failed (or has a documented intolerance or contraindication to) any of the following (please select all that apply)?

- Aripiprazole
- Olanzapine
- Risperidone
- Quetiapine
- Ziprasidone
- None of the above

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Hyperphosphatemia <input type="checkbox"/> Iron deficiency anemia <input type="checkbox"/> Other
Q4. Does the patient have chronic kidney disease (CKD)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Is the patient on dialysis? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Auryxia-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Chorea associated with Huntington's Disease <input type="checkbox"/> Tardive Dyskinesia - medication-induced <input type="checkbox"/> Other
Q4. For HUNTINGTON'S DISEASE, does the prescriber attest that patient has NOT taken an MAOI in the past 14 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. For TARDIVE DYSKINESIA, does the patient have a history of using a dopamine receptor antagonist? <input type="checkbox"/> Yes <input type="checkbox"/> No
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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Austedo-1 Medicare

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

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

Patient Name:	Prescriber Name:
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Q8. Is the requested medication being prescribed by (or in consultation with) a psychiatrist or neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Q9. Does the patient have any of the following (please select all that apply)? <input type="checkbox"/> Any degree of hepatic impairment or hepatic disease <input type="checkbox"/> Active suicidal ideation <input type="checkbox"/> Untreated or inadequately treated depression <input type="checkbox"/> None of the above
--

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosulif-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) (chronic, accelerated, or blast phase)</p> <p><input type="checkbox"/> Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) (newly diagnosed chronic phase)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For Ph+ CML IN THE CHRONIC, ACCELERATED, OR BLAST PHASE, has the patient had resistance, relapse, or inadequate response to prior therapy with one of the following tyrosine kinase inhibitors (TKI) (please select all that apply)?</p> <p><input type="checkbox"/> Gleevec (imatinib)</p> <p><input type="checkbox"/> Sprycel (dasatinib)</p> <p><input type="checkbox"/> Tassigna (nilotinib)</p> <p><input type="checkbox"/> None of the above</p>
<p>Q5. 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, disease is resistant or intolerant, etc)?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Bosulif-4 Medicare

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

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

Patient Name:	Prescriber Name:
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Q6. If the patient's diagnosis is OTHER, please specify below:

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

Yes No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Melanoma (unresectable or metastatic) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have BRAF V600E or V600K mutation as detected by an FDA-approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Will Braftovi be used in combination with Mektovi (binimetinib)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-3 Medicare

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabometyx-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Renal cell carcinoma (advanced) <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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabometyx-3 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Calquence-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Mantle cell lymphoma (MCL) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient received at least one (1) prior therapy for MCL? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is Calquence being prescribed by (or in consultation with) an oncologist? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Calquence-3 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):
Q3. For CONTINUING THERAPY, please select all that apply: <input type="checkbox"/> The patient is benefitting from treatment (for example, improvement in lung function [FEV1], decreased number of pulmonary exacerbations) <input type="checkbox"/> There is clinical reason to continue therapy (such as symptomatic improvement or pulmonary function tests have not deteriorated more than 10% from baseline) <input type="checkbox"/> None of the above
Q4. Please indicate that patient's diagnosis for the requested medication: <input type="checkbox"/> Cystic fibrosis (CF) <input type="checkbox"/> Other
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. Has the diagnosis been confirmed by appropriate diagnostic or genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Does the patient have evidence of P. aeruginosa in the lungs as confirmed by cultures of the airways?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Cayston-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the patient 7 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:
Copiktra-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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/small lymphocytic lymphoma (CLL/SLL), relapsed or refractory <input type="checkbox"/> Follicular lymphoma, relapsed or refractory <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient been treated with at least 2 prior therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the requested medication being prescribed by (or in consultation with) an oncologist or hematologist? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Copiktra-4 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Corlanor-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Chronic heart failure (stable, symptomatic) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient's left ventricular ejection fraction (LVEF) 35% or less?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient in sinus rhythm with resting heart rate of 70 beats per minute or more?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the patient on maximally tolerated doses of beta blockers OR has a contraindication to beta blocker use?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Is the patient 18 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-2 Medicare

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

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

Patient Name:	Prescriber Name:
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Yes

No

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

Decompensated acute heart failure

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

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

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

None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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. For CONTINUING THERAPY, is there documentation that the patient has had a positive clinical response to Cosentyx therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Ankylosing spondylitis (active) <input type="checkbox"/> Plaque psoriasis (moderate to severe) <input type="checkbox"/> Psoriatic arthritis (active) <input type="checkbox"/> Other</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Has the patient tried and failed (or has a contraindication or intolerance) 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>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-1 Medicare

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

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

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

<p>Q7. Will the patient be using Cosentyx in combination with any of the following (please select all that apply)?</p> <p><input type="checkbox"/> A biologic DMARD (such as Enbrel, Humira, Cimzia, or Simponi)</p> <p><input type="checkbox"/> A Janus kinase inhibitor (such as Xeljanz)</p> <p><input type="checkbox"/> None of the above</p>
<p>Q8. For PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS, will the patient be using Cosentyx in combination with a phosphodiesterase 4 (PDE4) inhibitor (such as Otezla)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Please indicate the prescriber's specialty below:</p> <p><input type="checkbox"/> Dermatologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> None of the above</p>

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Melanoma (unresectable or metastatic) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have BRAF V600E or V600K mutation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Will the requested medication be used in combination with vemurafenib (Zelboraf)? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> 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 crystal accumulation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-1 Medicare

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

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

Patient Name:	Prescriber Name:
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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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 (newly diagnosed) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Will Daurismo be used in combination with low-dose cytarabine? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the patient 75 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the medication being prescribed by (or in consultation with) an oncologist or hematologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Daurismo-1 Medicare

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Diclofenac Topical-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Actinic keratosis <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:

Diclofenac Topical-2 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dronabinol-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify 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 with weight loss in a patient with AIDS</p> <p><input type="checkbox"/> Nausea and vomiting (N/V) associated with cancer chemotherapy</p> <p><input type="checkbox"/> Other</p>
<p>Q4. FOR ANOREXIA: Has the patient had an involuntary weight loss of greater than 10% of pre-illness baseline body weight OR a body mass index (BMI) less than 20kg/m2 in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. FOR ANOREXIA: Has the patient failed to respond to a 30-day trial of megestrol (Megace)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. IF CONTINUING THERAPY FOR ANOREXIA: Has the patient shown a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Dronabinol-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. FOR N/V: Is the patient currently receiving a chemotherapy or radiation regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. FOR N/V: Is oral drug being used as a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen administered within 48 hours of chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. FOR N/V: Has the patient had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. FOR N/V: Has the patient tried and failed at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, or oral 5-HT3 receptor antagonists? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. IF CONTINUING THERAPY FOR N/V: Has the patient shown a positive response to therapy by reduced incidence of emesis and/or nausea? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. If the patient's diagnosis is OTHER, please specify below:	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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</p> <p><input type="checkbox"/> Plaque psoriasis (moderate to severe)</p> <p><input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (moderate to severe)</p> <p><input type="checkbox"/> Psoriatic arthritis</p> <p><input type="checkbox"/> Rheumatoid arthritis (moderate to severe)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Do any of the following apply to this patient (please select all that apply)?</p> <p><input type="checkbox"/> The patient has an active serious infection (including tuberculosis)</p> <p><input type="checkbox"/> The patient will be using Enbrel with another biologic disease-modifying anti-rheumatic drug (DMARD)</p> <p><input type="checkbox"/> The patient will be using Enbrel with potent immunosuppressant (such as azathioprine or cyclosporine)</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-1 Medicare

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

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

Patient Name:

Prescriber Name:

Q6. Has the patient tried and failed (or has a contraindication or intolerance to) one or more of the following (please select all that apply)?

- Methotrexate (MTX)
- Non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Conventional therapy with phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA]) for at least one continuous month
- Conventional therapy with oral systemic treatments (such as methotrexate, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months
- None of the above

Q7. For PLAQUE PSORIASIS, does the patient's disease affect more than 5% of the body surface area (BSA) or affect crucial body areas such as the hands, feet, face, or genitals?

- Yes No

Q8. Please indicate the patient's age below:

- Under 2 years
- 2-3 years
- 4-17 years
- 18 years or older

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Endari-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Sickle cell disease (acute) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient tried and failed (or has an intolerance or contraindication to) hydroxyurea?</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-3 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Entresto-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Heart failure <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Please select the patient's New York Heart Association (NYHA) Class of heart failure: <input type="checkbox"/> NYHA Class I <input type="checkbox"/> NYHA Class II <input type="checkbox"/> NYHA Class III <input type="checkbox"/> NYHA Class IV
Q6. Does the patient have any of the following EXCLUSIONS (please select all that apply)? <input type="checkbox"/> Patient has history of angioedema related to previous ACE-inhibitor or ARB therapy <input type="checkbox"/> Patient will be using Entresto concomitantly, or within 36 hours of an ACE-inhibitor <input type="checkbox"/> Entresto will be used concomitantly with aliskiren (Tekturna) in a diabetic patient <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Entresto-2 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Severe myoclonic epilepsy in infancy</p> <p><input type="checkbox"/> Lennox-Gestaut syndrome (LGS)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. Is the patient 2 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Is the requested medication being prescribed by (or in consultation with) a neurologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Epidiolex-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Prostate cancer (non-metastatic) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient's disease castration-resistant? <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 being prescribed by (or in consultation with) an oncologist or urologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the patient pregnant? <input type="checkbox"/> Yes



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Erleada-1 Medicare

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Patient Name:

Prescriber Name:

- | |
|---|
| <input type="checkbox"/> No
<input type="checkbox"/> N/A - The patient is not a female or not of child-bearing potential |
|---|

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
ESA-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<p>Q1. Is this request for initial therapy or continuing therapy? *</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> Anemia associated with chronic kidney disease (CKD)</p> <p><input type="checkbox"/> Anemia associated with myelosuppressive chemotherapy</p> <p><input type="checkbox"/> Anemia associated with zidovudine therapy in a patient with HIV infection</p> <p><input type="checkbox"/> Reduction of blood transfusions in a patient undergoing elective, non-cardiac, non-vascular surgery</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's pre-treatment hemoglobin level less than 10 g/dL?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Will there be a dose reduction or interruption if the hemoglobin level 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)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

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ESA-1 Medicare

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Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Esbriet-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Idiopathic pulmonary fibrosis (IPF) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the prescriber a pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Will the patient's hepatic function and liver function tests (LFTs) be monitored? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Esbriet-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Farydak-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> 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. Will Farydak be used in combination with bortezomib (Velcade) and dexamethasone? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Has the patient received at least two (2) prior regimens, including bortezomib (Velcade) and an immunomodulatory agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)]? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the requested medication being prescribed by (or in consultation with) an oncologist/hematologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Farydak-1 Medicare

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl Oral-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Breakthrough cancer pain (in an opioid-tolerant patient) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient 16 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient is taking any strong or moderate cytochrome P450 (CYP450) 3A4 inhibitors, (such as aprepitant, clarithromycin, diltiazem, erythromycin, fosamprenavir, fluconazole, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, verapamil) will they be monitored or have dosing adjustments made if necessary?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A - Patient is not taking any strong CYP450 3A4 inhibitors</p>
<p>Q7. The plan has the following quantity limits in place: 120 lozenges per 30 days. Will the patient require a quantity</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl Oral-3 Medicare

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

Patient Name:	Prescriber Name:
greater than this? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. If the patient requires a quantity greater than specified above, please provide rationale for a quantity limit exception:	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Filgrastim-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy

Q2. For continuing therapy, please specify start date (MM/YY):

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

- Febrile neutropenia, In non-myeloid malignancies following myelosuppressive chemotherapy; Prophylaxis
- Febrile neutropenia, In non-myeloid malignancies, in patients undergoing myeloablative chemotherapy followed by marrow transplantation; Prophylaxis
- Febrile neutropenia, In patients with acute myeloid leukemia receiving chemotherapy; Prophylaxis
- Harvesting of peripheral blood stem cells
- Hematopoietic subsyndrome of acute radiation syndrome
- Neutropenic disorder, chronic (Severe), Symptomatic
- Other

Q4. For patients with non-myeloid malignancies receiving myelosuppressive chemotherapy, please select if any of the following apply to this patient:

- Patient experienced febrile neutropenia with a prior chemotherapy cycle
- The patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia
- Patient is at low risk (less than 10%) but is at significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease
- For the treatment of febrile neutropenia in patients who have received prophylaxis with Neupogen or Zarxio



COVERAGE DETERMINATION REQUEST FORM

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Filgrastim-3 Medicare

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Patient Name:	Prescriber Name:
(or Leukine) OR in patients at risk for infection-related complications <input type="checkbox"/> None of the above	
Q5. If the patient's diagnosis is OTHER, please specify below:	
Q6. Are the patient's complete blood count and platelet count being monitored at baseline, and regularly thereafter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Please indicate if any of the following apply to this patient (select all that apply): <input type="checkbox"/> Administration within 24 hours preceding or following chemotherapy or radiotherapy <input type="checkbox"/> E. coli hypersensitivity <input type="checkbox"/> For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule beyond established regimens <input type="checkbox"/> Treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle <input type="checkbox"/> None of the above	

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Firdapse-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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

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Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Galafold-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Fabry disease <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have an amenable galactosidase alpha gene (GLA) mutation? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Galafold-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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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gilotrif-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Non-small cell lung cancer (NSCLC), metastatic squamous (previously treated) <input type="checkbox"/> Other
Q4. Has the patient's disease progressed following platinum-based chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. If the patient's diagnosis is OTHER, please specify below:
Q6. Do the patient's tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test? <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



COVERAGE DETERMINATION REQUEST FORM

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Gilotrif-2 Medicare

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

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

Patient Name:

Prescriber Name:

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

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gocovri-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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. For CONTINUING THERAPY, has the patient experienced a positive clinical response to Gocovri (such as decreased "off" periods, or decreased "on" time with troublesome dyskinesia)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Parkinson disease <input type="checkbox"/> Other</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Please check all that apply to this patient:</p> <p><input type="checkbox"/> Patient is experiencing dyskinesia</p> <p><input type="checkbox"/> Patient is receiving levodopa based therapy</p> <p><input type="checkbox"/> Patient has tried and failed amantadine immediate release</p> <p><input type="checkbox"/> None of the above</p>
<p>Q7. Does the patient have end stage renal disease (ESRD) (CrCl below 15 mL/min/m2)?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gocovri-4 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the requested medication being prescribed by (or in consultation with) a neurologist?	
<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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?	
<input type="checkbox"/> Initial therapy	<input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):	
Q3. For CONTINUING THERAPY (ADULT PATIENTS), please select all that apply:	
<input type="checkbox"/> Patient has seen clinical improvement	
<input type="checkbox"/> IGF-1 will be monitored	
<input type="checkbox"/> None of the above	
Q4. Please indicate the patient's diagnosis for the requested medication:	
<input type="checkbox"/> Growth failure in children	<input type="checkbox"/> Growth failure in a pediatric patient born small for gestational age (SGA)
<input type="checkbox"/> Growth failure associated with chronic kidney disease (CKD)	<input type="checkbox"/> Growth Hormone Deficiency (GHD) in neonates with hypoglycemia
<input type="checkbox"/> Growth failure associated with Noonan Syndrome	<input type="checkbox"/> Growth Hormone Deficiency (GHD) in pediatrics
<input type="checkbox"/> Growth failure associated with Prader-Willi Syndrome	<input type="checkbox"/> Growth Hormone Deficiency (GHD) in adults
<input type="checkbox"/> Growth failure associated with short stature homeobox gene (SHOX) deficiency	<input type="checkbox"/> Idiopathic short stature
<input type="checkbox"/> Growth failure or short stature associated with Turner Syndrome	<input type="checkbox"/> Other



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

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

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

Patient Name:	Prescriber Name:
<p>Q5. For GROWTH FAILURE ASSOCIATED WITH CKD, please select all that apply:</p> <p><input type="checkbox"/> Metabolic, endocrine, and nutritional abnormalities have been treated or stabilized</p> <p><input type="checkbox"/> The patient has not had a kidney transplant</p> <p><input type="checkbox"/> None of the above</p>	
<p>Q6. For GROWTH FAILURE ASSOCIATED WITH TURNER SYNDROME OR SHOX, has the diagnosis been confirmed by genetic testing?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q7. For GROWTH FAILURE IN A PATIENT BORN SHORT FOR GESTATIONAL AGE (SGA), did the patient have a low birth weight or length for gestational age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q8. For GHD IN NEONATES WITH HYPOGLYCEMIA, please select all that apply:</p> <p><input type="checkbox"/> The patient has a randomly assessed growth hormone (GH) level less than 20 ng/mL</p> <p><input type="checkbox"/> Other causes of hypoglycemia have been ruled out</p> <p><input type="checkbox"/> Other treatments have been ineffective</p> <p><input type="checkbox"/> None of the above</p>	
<p>Q9. For PEDIATRIC GHD, please select all that apply:</p> <p><input type="checkbox"/> The patient has delayed bone age</p> <p><input type="checkbox"/> The patient does not have pituitary disease, and has failed 2 stimulation tests</p> <p><input type="checkbox"/> The patient has pituitary or CNS disorder, and has clinical evidence of GHD and low IGF-1/IGFBP3</p> <p><input type="checkbox"/> None of the above</p>	
<p>Q10. For ADULT GHD, please select all of the following that apply to this patient:</p> <p><input type="checkbox"/> The patient was assessed for other causes of GHD-like symptoms</p> <p><input type="checkbox"/> The patient does not have pituitary disease, and has failed 2 stimulation tests</p> <p><input type="checkbox"/> The patient has pituitary disease with at least 3 pituitary hormone deficiencies (PHD) or panhypopituitarism, and has low IGF-1</p> <p><input type="checkbox"/> The patient has pituitary disease with less than 3 PHD, has low IGF-1, and has failed 1 stimulation test</p> <p><input type="checkbox"/> None of the above</p>	
<p>Q11. For IDIOPATHIC SHORT STATUTE, has pediatric GHD been ruled out with at least one (1) stimulation test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q12. If the patient's diagnosis is OTHER, please specify below:</p>	
<p>Q13. Please select the prescriber's specialty below:</p> <p><input type="checkbox"/> Endocrinologist</p>	



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Growth Hormone-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Infectious disease (ID) specialist <input type="checkbox"/> Nutritional support specialist <input type="checkbox"/> Pediatric nephrologist <input type="checkbox"/> None of the above	
Q14. Please indicate the patient's age below: <input type="checkbox"/> Under 2 years of age <input type="checkbox"/> 2-3 years of age <input type="checkbox"/> 3 years of age or older	
Q15. For PEDIATRIC PATIENTS, please select all that apply: <input type="checkbox"/> The patient has short stature or slow growth velocity <input type="checkbox"/> The patient has been evaluated for other causes of growth failure <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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 C <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. Please indicate the prescriber's specialty below:</p> <p><input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> Other</p>
<p>Q7. If the prescriber's specialty is OTHER, please specify:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepatitis C-1 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Please provide the patient's genotype confirmed by HCV RNA level within the last 6 months (must submit documentation):	
Q9. Please provide the patient's subtype (must submit documentation):	
Q10. Please provide the patient's HCV RNA (viral load) level (must submit documentation):	
Q11. Is the patient post-transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. What is the patient's cirrhosis status?	
Q13. What is the patient's prior treatment history?	
Q14. What is the patient's planned duration of treatment?	
Q15. Has the prescriber documented the following within 12 weeks of initiating therapy: 1) CBC w Platelets, 2) AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR, 6) Serum Creatinine, and 7) GFR? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. For Vosevi: Has the patient previously tried and failed (or had a contraindication or intolerance to) Mavyret? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A - The request is for Mavyret	

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepatitis C-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hetlioz-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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-24-hour-sleep-wake disorder (Non-24) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have documented blindness? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hetlioz-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM ADHD-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial <input type="checkbox"/> Continuing
Q2. For continuing therapy, please specify start date (MM/YY):
Q3. Is the patient greater than or equal to 65 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Please indicate the diagnosis for which the requested medication is being prescribed: <input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD) <input type="checkbox"/> Hypertension <input type="checkbox"/> Other
Q5. If the diagnosis is OTHER, please specify.



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM ADHD-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Analgesics-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Please indicate the diagnosis for which the requested medication is being prescribed:</p> <p><input type="checkbox"/> Tension or muscle contraction headache</p> <p><input type="checkbox"/> Acute Pain</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Ankylosing Spondylitis</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Other</p>
<p>Q5. If the diagnosis is OTHER, please specify below:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Analgesics-3 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Anti-Arrhythmics-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial <input type="checkbox"/> Continuing</p>
<p>Q2. For continuing therapy, please specify start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis below:</p> <p><input type="checkbox"/> Ventricular arrhythmia <input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify.</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. FOR PRESCRIBER INFORMATION ONLY: For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Disopyramide: rate control preferred for atrial fibrillation.</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Anti-Arrhythmics-3 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antidepressants-8 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial <input type="checkbox"/> Continuing
Q2. For continuing therapy, please specify start date (MM/YY):
Q3. Please indicate which medication is being requested: <input type="checkbox"/> Amitriptyline <input type="checkbox"/> Doxepin <input type="checkbox"/> Clomipramine (Anafranil) <input type="checkbox"/> Imipramine HCl (Tofranil) <input type="checkbox"/> Imipramine Pamoate (Tofranil-PM) <input type="checkbox"/> Trimipramine (Surmontil) <input type="checkbox"/> None of the above <input type="checkbox"/> Other
Q4. If medication is Other, please specify:
Q5. Please provide the patient's diagnosis below: <input type="checkbox"/> Obsessive-Compulsive Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antidepressants-8 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Enuresis <input type="checkbox"/> Other	
Q6. If the diagnosis is OTHER, please specify.	
Q7. Is the patient greater than or equal to 65 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Antiemetics-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 Start Date (MM/YY):</p>
<p>Q3. Please indicate which medication is requested:</p> <p><input type="checkbox"/> Hydroxyzine <input type="checkbox"/> Promethazine <input type="checkbox"/> Trimethobenzamide <input type="checkbox"/> Other</p>
<p>Q4. If medication is Other, Please specify:</p>
<p>Q5. Is the patient 65 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Pruritus/Allergic conditions <input type="checkbox"/> Sedation <input type="checkbox"/> Anxiety/tension <input type="checkbox"/> Nausea/Vomiting</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Antiemetics-3 Medicare

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

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

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

<input type="checkbox"/> Motion sickness <input type="checkbox"/> Adjunct to analgesia <input type="checkbox"/> Other

Q7. If the patient's diagnosis is OTHER, please specify below:
--

Q8. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Nausea/Vomiting: granisetron, ondansetron. Allergic Reactions: levocetirizine

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antihistamines-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For continuing therapy, please specify start date (MM/YY):
Q3. Please indicate the patient's diagnosis below: <input type="checkbox"/> Allergic/vasomotor rhinitis <input type="checkbox"/> Allergic conjunctivitis <input type="checkbox"/> Urticaria <input type="checkbox"/> Hypersensitivity reaction <input type="checkbox"/> Other
Q4. If the diagnosis is OTHER, please specify below:
Q5. Is the patient greater than or equal to 65 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antihistamines-4 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antiparkinson Agents-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis below:</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Extrapyrimalidal disease - Medication-induced movement disorder</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antiparkinson Agents-4 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antipsychotics-6 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<p>Q1. Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial <input type="checkbox"/> Continuing</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"/> Schizophrenia <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antipsychotics-6 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Barbiturates-5 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the diagnosis for which the requested medication is being prescribed:</p> <p><input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Insomnia <input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: a) ANXIETY: (citalopram, escitalopram, fluvoxamine, sertraline, duloxetine, venlafaxine, buspirone) b) INSOMNIA: low dose trazodone.</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Barbiturates-5 Medicare

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

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

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Prescriber Name:

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Dementia Agents-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Dementia (progressive, Alzheimer's, or senile onset) <input type="checkbox"/> Other</p>
<p>Q4. If 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>
<p>Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Antidementia: donepezil, galantamine, memantine ER, rivastigmine capsule, rivastigmine patch.</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Dementia Agents-4 Medicare

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

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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Estrogens-7 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the diagnosis for which this medication is being prescribed:</p> <p><input type="checkbox"/> Abnormal vasomotor function (Moderate to Severe) - Menopause</p> <p><input type="checkbox"/> Atrophic vulva/vagina (Moderate to Severe) - Menopause</p> <p><input type="checkbox"/> Prevention of postmenopausal osteoporosis</p> <p><input type="checkbox"/> Decreased estrogen level, Secondary to hypogonadism, castration, or primary ovarian failure</p> <p><input type="checkbox"/> Breast cancer, Metastatic; for palliation only</p> <p><input type="checkbox"/> Prostate cancer, Advanced, Androgen-dependent; for palliation only</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 greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Localized options: Premarin Cream and Estradiol Cream. Osteoporosis: Alendronate and Risedronate.</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Estrogens-7 Medicare

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

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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Muscle Relaxant-8 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Acute Painful Musculoskeletal conditions</p> <p><input type="checkbox"/> Chronic Intermittent Painful Musculoskeletal conditions</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Restless Leg Syndrome</p> <p><input type="checkbox"/> Nocturnal Leg Cramps</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify:</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Muscle Relaxant-8 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Oncology-6 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 diagnosis for which the requested medication is being prescribed: *</p> <p><input type="checkbox"/> Cachexia associated with AIDS</p> <p><input type="checkbox"/> Breast cancer, palliative treatment of advanced disease</p> <p><input type="checkbox"/> Endometrial carcinoma, palliative treatment of advanced disease</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives for diagnosis of cachexia secondary to chronic illness are: dronabinol, oxandrolone.</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
HRM Oncology-6 Medicare

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

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

Patient Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Platelet Inhibitors-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis below:</p> <p><input type="checkbox"/> Heart valve replacement - Thromboembolic disorder; Prophylaxis</p> <p><input type="checkbox"/> Cerebrovascular accident; Prophylaxis</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Platelet Inhibitors: Cilostazol, Clopidogrel.</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Platelet Inhibitors-4 Medicare

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

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

Patient Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Sedative Hypnotics-7 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 Start Date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis:</p> <p><input type="checkbox"/> Insomnia <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient greater than or equal to 65 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Sedative Hypnotics-7 Medicare

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

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

Patient Name:

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Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify the start date (MM/YY):</p>										
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <table> <tbody> <tr> <td><input type="checkbox"/> Ankylosing Spondylitis</td> <td><input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (pJIA) (moderate to severe)</td> </tr> <tr> <td><input type="checkbox"/> Crohn's Disease (moderate to severe)</td> <td><input type="checkbox"/> Psoriatic arthritis</td> </tr> <tr> <td><input type="checkbox"/> Hidradenitis suppurativa (moderate to severe)</td> <td><input type="checkbox"/> Rheumatoid arthritis (moderate to severe)</td> </tr> <tr> <td><input type="checkbox"/> Non-infectious Uveitis (including intermediate, posterior, and panuveitis)</td> <td><input type="checkbox"/> Ulcerative colitis (moderate to severe)</td> </tr> <tr> <td><input type="checkbox"/> Plaque psoriasis (chronic)</td> <td><input type="checkbox"/> Other</td> </tr> </tbody> </table>	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (pJIA) (moderate to severe)	<input type="checkbox"/> Crohn's Disease (moderate to severe)	<input type="checkbox"/> Psoriatic arthritis	<input type="checkbox"/> Hidradenitis suppurativa (moderate to severe)	<input type="checkbox"/> Rheumatoid arthritis (moderate to severe)	<input type="checkbox"/> Non-infectious Uveitis (including intermediate, posterior, and panuveitis)	<input type="checkbox"/> Ulcerative colitis (moderate to severe)	<input type="checkbox"/> Plaque psoriasis (chronic)	<input type="checkbox"/> Other
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (pJIA) (moderate to severe)									
<input type="checkbox"/> Crohn's Disease (moderate to severe)	<input type="checkbox"/> Psoriatic arthritis									
<input type="checkbox"/> Hidradenitis suppurativa (moderate to severe)	<input type="checkbox"/> Rheumatoid arthritis (moderate to severe)									
<input type="checkbox"/> Non-infectious Uveitis (including intermediate, posterior, and panuveitis)	<input type="checkbox"/> Ulcerative colitis (moderate to severe)									
<input type="checkbox"/> Plaque psoriasis (chronic)	<input type="checkbox"/> Other									
<p>Q4. For PLAQUE PSORIASIS, does the patient's disease affect more than 5% of the body surface area (BSA) or affect crucial body areas such as the hands, feet, face, or genitals?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>										
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>										
<p>Q6. Has the patient tried and failed (or has a contraindication or intolerance to) any of the following (please select all that apply)?</p>										



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> RA or pJIA - one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months <input type="checkbox"/> PSORIATIC ARTHRITIS - methotrexate <input type="checkbox"/> ANKYLOSING SPONDYLITIS - one or more non-steroidal anti-inflammatory drugs (NSAIDs) <input type="checkbox"/> PLAQUE PSORIASIS - conventional therapy with phototherapy (such as UVA with a psoralen [PUVA] and/or retinoids [RePUVA]) for at least one continuous month <input type="checkbox"/> PLAQUE PSORIASIS - conventional therapy with one or more oral systemic treatments (such as cyclosporine, acitretin, sulfasalazine, methotrexate, leflunomide, azathioprine) for at least 3 consecutive months	<input type="checkbox"/> CROHN'S DISEASE - two or more corticosteroids or non-biologic DMARDs <input type="checkbox"/> ULCERATIVE COLITIS - two or more corticosteroids, 5-ASA (such as mesalamine, sulfasalazine, balsalazide), or non-biologic DMARDs (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, sulfasalazine) <input type="checkbox"/> UVEITIS - one of the following: systemic or topical corticosteroids or ophthalmic antimuscarinics <input type="checkbox"/> None of the above
<p>Q7. Please indicate the patient's age below:</p> <input type="checkbox"/> Under 2 years <input type="checkbox"/> 2-5 years <input type="checkbox"/> 6-11 years <input type="checkbox"/> 12-17 years old <input type="checkbox"/> 18 years or older	
<p>Q8. Does the patient have any active serious infections (including tuberculosis [TB])?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q9. Will the patient be using Humira in combination with a biologic disease-modifying anti-rheumatic drugs or potent immunosuppressant (such as azathioprine or cyclosporine)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ibrance-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Breast cancer, advanced or metastatic (initial endocrine-based therapy)</p> <p><input type="checkbox"/> Breast cancer, advanced or metastatic (second-line endocrine-based therapy)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. Is the patient a post-menopausal female?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Did the patient experience disease progression following previous endocrine based therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient's diagnosis is OTHER, please specify below:.</p>
<p>Q7. 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>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ibrance-1 Medicare

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

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

Patient Name:	Prescriber Name:
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Q8. Will any of the following medications be used in combination with Ibrance (please select all that apply)?	
<input type="checkbox"/> Aromatase inhibitor such as letrozole (Femara)	
<input type="checkbox"/> Fulvestrant (Faslodex)	
<input type="checkbox"/> None of the above	
Q9. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is the 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:
Iclusig-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Acute lymphoblastic leukemia, Philadelphia chromosome-positive (Ph+ALL)</p> <p><input type="checkbox"/> Chronic myeloid leukemia (CML) (chronic, accelerated, or blast phase)</p> <p><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 (please select all that apply):</p> <p><input type="checkbox"/> No other tyrosine kinase inhibitor therapy is indicated for this patient</p> <p><input type="checkbox"/> The patient is T315I-positive</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. Please indicate the prescriber's specialty below:</p> <p><input type="checkbox"/> Hematologist <input type="checkbox"/> Oncologist <input type="checkbox"/> Other</p>
<p>Q7. If the prescriber's specialty is OTHER, please specify below:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iclusig-2 Medicare

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

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

Patient Name:

Prescriber Name:

--

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Idhifa-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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), relapsed/refractory <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have an an isocitrate dehydrogenase 2 mutation as detected by an 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) a hematologist or oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Idhifa-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Imbruvica-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Chronic graft-versus-host-disease (cGVHD) (after failure of one or more lines of systemic therapy)</p> <p><input type="checkbox"/> Chronic lymphocytic leukemia (CLL) with or without 17p deletion</p> <p><input type="checkbox"/> Mantle cell lymphoma (MCL) (in patients who have received at least 1 prior therapy)</p> <p><input type="checkbox"/> Marginal zone lymphoma, relapsed/refractory (in patients who require systemic therapy and have received at least 1 prior anti-CD20-based therapy)</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>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Imbruvica-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Increlex-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> Severe primary insulin-like growth factor-1 deficiency (IGF-1 deficiency; primary IGFD)</p> <p><input type="checkbox"/> Growth hormone (GH) gene deletion in a patient that has developed neutralizing antibodies to growth hormone</p> <p><input type="checkbox"/> Genetic mutation of GH receptor (i.e. Laron Syndrome)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient's IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Increlex-3 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Does the patient have normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is there evidence of open epiphyses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Does the patient have allergies to mecasermin or any component of the Increlex formulation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Will the medication be used for growth promotion in patients with closed epiphyses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Will Increlex be administered intravenously? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Does the patient have active or suspected neoplasia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Please indicate the prescriber's specialty below: <input type="checkbox"/> Pediatrics <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Other	
Q14. If the prescriber's specialty is other, please describe below:	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Intrarosa-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Dyspareunia (moderate to severe)</p> <p><input type="checkbox"/> Atrophic vaginitis</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's condition caused by menopause?</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"/> Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin</p> <p><input type="checkbox"/> Known or suspected estrogen-dependent neoplasia</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Intrarosa-1 Medicare

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

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

Patient Name:

Prescriber Name:

None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iressa-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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 known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the medication prescribed by (or in consultation with) an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the patient 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iressa-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iron Overload-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify the start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication below: *</p> <p><input type="checkbox"/> Chronic iron overload in nontransfusional-dependent thalassemia syndromes</p> <p><input type="checkbox"/> Chronic iron overload due to blood transfusions</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 patient's age:</p> <p><input type="checkbox"/> Under 2 years <input type="checkbox"/> 2 years and older</p>
<p>Q6. What is the patient's serum creatinine level?</p>
<p>Q7. What is the patient's serum ferritin level?</p>
<p>Q8. Is the requested medication prescribed by a hematologist?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Iron Overload-1 Medicare

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

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

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

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the diagnosis for which Itraconazole is being requested: *</p> <p><input type="checkbox"/> Systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis)</p> <p><input type="checkbox"/> Onychomycosis</p> <p><input type="checkbox"/> Candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole (ORAL SOLUTION ONLY)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify below:</p>
<p>Q5. For ONYCHOMYCHOSIS, has the diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Itraconazole-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
IVIG-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the diagnosis for which IVIG therapy is being requested:</p> <p><input type="checkbox"/> Acute and chronic immune Idiopathic Thrombocytopenic Purpura (ITP)</p> <p><input type="checkbox"/> Chronic inflammatory demyelinating polyneuropathy (CIDP)</p> <p><input type="checkbox"/> Primary humoral immunodeficiency syndrome (congenital agammaglobulinemia, severe combined immunodeficiency syndromes [SCIDS], common variable immunodeficiency, X-linked immunodeficiency, Wiskott-Aldrich syndrome)</p> <p><input type="checkbox"/> Prevention of bacterial infection in patients with hypogammaglobulinemia and/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"/> Motor neuropathy with multiple conduction block</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For CIDP: Has diagnosis been confirmed by a neurologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. If the diagnosis is OTHER, please specify below:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
IVIG-1 Medicare

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Patient Name:	Prescriber Name:
Q6. Does the patient have IgA deficiency with antibody formation and a history of hypersensitivity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Does the patient have a history of anaphylaxis or severe systemic reaction to human immune globulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the patient have any risk factor(s) for acute renal failure, unless the patient will receive IVIG products at the minimum concentration available and at the minimum rate of infusion practicable? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. If IVIG will be administered via subcutaneous route outside of a controlled healthcare setting, will appropriate treatment (eg, anaphylaxis kit) be available for managing an acute hypersensitivity reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Juxtapid-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the patient had an inadequate response or intolerance to statins?</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"/> Moderate to severe liver impairment</p> <p><input type="checkbox"/> Active liver disease including unexplained persistent abnormal liver function tests</p> <p><input type="checkbox"/> Pregnant</p> <p><input type="checkbox"/> Concomitant use with strong or moderate CYP3A4 inhibitors</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Juxtapid-3 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Kalydeco potentiation based on clinical and/or in vitro assay data?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For CONTINUING THERAPY, has the patient experienced improved or stable lung function while on Kalydeco therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kalydeco-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Breast cancer (advanced or metastatic) <input type="checkbox"/> Other</p>
<p>Q4. Please select all that apply to this patient:</p> <p><input type="checkbox"/> The patient is a postmenopausal female</p> <p><input type="checkbox"/> The patient is a premenopausal or perimenopausal female</p> <p><input type="checkbox"/> The patient's disease is hormone receptor (HR)-positive</p> <p><input type="checkbox"/> The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative</p> <p><input type="checkbox"/> The medication will be used in combination with an aromatase inhibitor for initial endocrine-based treatment</p> <p><input type="checkbox"/> The medication will be used in combination with fulvestrant as initial endocrine based therapy or following disease progression on endocrine therapy</p> <p><input type="checkbox"/> None of the above</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Is the patient 18 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kisqali-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. 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:
Korlym-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Hyperglycemia (in a patient with endogenous Cushing's syndrome who has failed surgery or who is ineligible for surgery) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient is not female</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Korlym-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kuvan-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing Therapy
Q2. For continuing therapy, please specify start date (MM/YY):
Q3. Please indicate the diagnosis for which the requested medication is being prescribed: * <input type="checkbox"/> To reduce blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA) <input type="checkbox"/> Other
Q4. If the diagnosis is OTHER, please specify below:
Q5. What is the patient's age? <input type="checkbox"/> 12 years or younger <input type="checkbox"/> Greater than 12 years
Q6. What is the pretreatment blood phenylalanine (Phe) level? <input type="checkbox"/> Greater than or equal to 10mg/dl <input type="checkbox"/> Between 6mg/dl and 10mg/dl <input type="checkbox"/> Less than 6mg/dl
Q7. Will blood Phe levels be checked after 1 week of therapy and periodically up to one month during a therapeutic trial? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kuvan-2 Medicare

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

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

Patient Name:

Prescriber Name:

Q8. For CONTINUING THERAPY, is there a response to a therapeutic trial as defined by greater than or equal to 30% reduction in baseline Phe levels?

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kynamro-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Homozygous familial hypercholesterolemia <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient tried and failed or had an intolerance to statins? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Does the patient have moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. For CONTINUING THERAPY, has the patient responded to therapy with a decrease in LDL levels? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kynamro-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:

Lenvima-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Hepatocellular carcinoma (unresectable)</p> <p><input type="checkbox"/> Renal cell carcinoma (advanced)</p> <p><input type="checkbox"/> Thyroid cancer, differentiated (locally recurrent or metastatic, progressive)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For RENAL CELL CARCINOMA, will the requested medication be used in combination with everolimus (Afinitor)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. For RENAL CELL CARCINOMA, has the patient received at least one (1) prior anti-angiogenic therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For THYROID CANCER, is the patient's disease refractory to radioactive iodine?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. If the patient's diagnosis is OTHER, please specify below:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lenvima-1 Medicare

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

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

Patient Name:

Prescriber Name:

--

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Letairis-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Pulmonary arterial hypertension (PAH), WHO Group I <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. For PAH, has the diagnosis been 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
Q6. Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. For FEMALE PATIENTS OF CHILD-BEARING POTENTIAL, please select all that apply: <input type="checkbox"/> Pregnancy has been excluded prior to the start of therapy <input type="checkbox"/> The patient has been educated about the potential hazards associated with Letairis use in pregnancy <input type="checkbox"/> Women of childbearing potential will be using an IUD or two appropriate contraceptive methods



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Letairis-2 Medicare

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

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

Patient Name:

Prescriber Name:

- None of the above
- N/A - The patient is not a female of child-bearing potential

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the diagnosis for which Leukine is being requested:</p> <p><input type="checkbox"/> Acute myelogenous leukemia (AML), following induction chemotherapy</p> <p><input type="checkbox"/> Bone marrow transplant (allogeneic or autologous) failure or engraftment delay</p> <p><input type="checkbox"/> Myeloid reconstitution after allogeneic bone marrow transplantation</p> <p><input type="checkbox"/> Myeloid reconstitution after autologous bone marrow transplantation: Non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL), Hodgkin's lymphoma</p> <p><input type="checkbox"/> Peripheral stem cell transplantation: Mobilization and myeloid reconstitution following autologous peripheral stem cell transplantation</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For AML only, is there excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> N/A - patient does not have AML</p>
<p>Q5. If the diagnosis is OTHER, please specify below:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Leukine-1 Medicare

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

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

Patient Name:	Prescriber Name:
<p>Q6. For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy, please check all that apply:</p> <p><input type="checkbox"/> Leukine is being used for the prevention of chemotherapy-induced febrile neutropenia and the patient has experienced febrile neutropenia with a prior chemotherapy cycle</p> <p><input type="checkbox"/> The patient is at high risk (greater than 20%) for developing febrile neutropenia</p> <p><input type="checkbox"/> The patient is at intermediate risk (10-20%) for developing febrile neutropenia.</p> <p><input type="checkbox"/> The patient at low risk (less than 10%) for developing febrile neutropenia and there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease.</p> <p><input type="checkbox"/> None of the above</p>	
<p>Q7. Is Leukine being requested for treatment of febrile neutropenia in a patient who has received prophylaxis with Leukine (or Neupogen)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q8. Will patient receive baseline and regular monitoring of complete blood counts and platelet counts?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q9. Is patient at risk for infection-related complications?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q10. Will Leukine be administered within 24 hours preceding or following chemotherapy or radiotherapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q11. Is Leukine being used for prophylaxis to to increase the chemotherapy dose intensity or dose schedule above established regimens?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q12. For treatment of febrile neutropenia: Did the patient receive Neulasta during the current chemotherapy cycle?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q13. Does patient have a known hypersensitivity to yeast-derived products?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Leukine-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 below (MM/YY):</p>
<p>Q3. Does the patient have postherpetic neuralgia?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the patient have diabetic peripheral neuropathy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. If the diagnosis is NOT postherpetic neuralgia or diabetic peripheral neuropathy, please specify the patient's diagnosis below:</p>
<p>Q6. Has the patient previously tried and failed (or had an intolerance or contraindication to) at least one of the following medications which are labeled for the treatment of diabetic neuropathy (please check all that apply)?</p> <p><input type="checkbox"/> Cymbalta <input type="checkbox"/> Lyrica <input type="checkbox"/> Other <input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lidocaine Patch-1 Medicare

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

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

Patient Name:	Prescriber Name:
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Q7. If the medication is OTHER, please specify below:

Q8. If the patient has NOT tried any of the medications listed in the previous questions, is there a reason 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:
Lorbrena-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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 anaplastic lymphoma kinase (ALK)-positive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Has the patient experienced disease progression on any of the following (please select all that apply)? <input type="checkbox"/> Alectinib (Alecensa) <input type="checkbox"/> Ceritinib (Zykadia) <input type="checkbox"/> Crizotinib (Xalkori) AND at least 1 other ALK inhibitor for metastatic disease <input type="checkbox"/> None of the above
Q7. Will the patient be taking this medication in combination with a strong CYP3A inducer? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lorbrena-3 Medicare

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

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

Patient Name:	Prescriber Name:
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:
Lupron-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 Start Date (MM/YY):</p>
<p>Q3. Please indicate which medication the request is for:</p> <p><input type="checkbox"/> Leuprolide</p> <p><input type="checkbox"/> Lupron Depot Injection 3.75 mg</p> <p><input type="checkbox"/> Lupron Depot Injection 7.5 mg</p> <p><input type="checkbox"/> Lupron Depot Injection 11.25</p> <p><input type="checkbox"/> Lupron Depot Injection 22.5 mg</p> <p><input type="checkbox"/> Lupron Depot Injection 30 mg</p> <p><input type="checkbox"/> Lupron Depot Injection 45 mg</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If medication is Other, Please specify:</p>
<p>Q5. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Prostate cancer (advanced or metastatic)</p> <p><input type="checkbox"/> Endometriosis</p> <p><input type="checkbox"/> Anemia due to uterine Leiomyomata (Fibroids)</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupron-2 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Central precocious puberty (idiopathic or neurogenic) in children <input type="checkbox"/> Other	
Q6. For ANEMIA DUE TO UTERINE LEIOMYOMATA (FIBROIDS), please select all that apply: <input type="checkbox"/> Patient is preoperative <input type="checkbox"/> None of the above	
Q7. If the patient's diagnosis is OTHER, please specify below.	
Q8. For FEMALE PATIENTS, select all that apply: <input type="checkbox"/> Patient is pregnant <input type="checkbox"/> Patient is breastfeeding <input type="checkbox"/> Patient has undiagnosed abnormal vaginal bleeding <input type="checkbox"/> None of the above	
Q9. Will the patient be utilizing non-hormonal contraceptives during and for 12 weeks after therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lynparza-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 which medication this request is for:</p> <p><input type="checkbox"/> Lynparza capsules <input type="checkbox"/> Lynparza tablets</p>
<p>Q4. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Breast cancer, metastatic</p> <p><input type="checkbox"/> Epithelial ovarian, fallopian tube, or primary peritoneal cancer (recurrent)</p> <p><input type="checkbox"/> Ovarian cancer, advanced</p> <p><input type="checkbox"/> Other</p>
<p>Q5. For METASTATIC BREAST CANCER, please select all that apply to this patient:</p> <p><input type="checkbox"/> The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative</p> <p><input type="checkbox"/> The patient has deleterious or suspected deleterious germline BRCA mutation (gBRCAm)</p> <p><input type="checkbox"/> The patient has been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, has the patient had a complete or partial response to platinum-based chemotherapy?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lynparza-3 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. For ADVANCED OVARIAN CANCER, please select all that apply to this patient: <input type="checkbox"/> The patient has deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) advanced ovarian cancer <input type="checkbox"/> The patient has been treated with three (3) or more prior lines of chemotherapy <input type="checkbox"/> None of the above	
Q8. If the patient's diagnosis is OTHER, please specify below:	

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is 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"/> Melanoma (adjuvant treatment) <input type="checkbox"/> Melanoma (unresectable or metastatic) <input type="checkbox"/> Non-small cell lung cancer (metastatic) (with BRAF V600E mutation) <input type="checkbox"/> Thyroid cancer, anaplastic (locally advanced or metastatic) (with BRAF V600E mutation) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have documented BRAF V600E or V600K mutations as detected by an FDA-approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the requested medication being prescribed by an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mekinist-2 Medicare

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

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Patient Name:	Prescriber Name:
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Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mektovi-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Melanoma (unresectable or metastatic malignant) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have BRAF V600E or V600K mutation as detected by an FDA-approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Will Mektovi be used in combination with Braftovi (encorafenib)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mektovi-3 Medicare

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Miglustat-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Gaucher disease, type 1 (mild to moderate) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient a candidate for enzyme replacement 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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Miglustat-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Multiple Sclerosis-5 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):
Q3. For CONTINUING THERAPY, has the patient experienced an objective response to therapy (such as no or slowed progression of disease)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Please indicate which medication this request is for: <input type="checkbox"/> Aubagio <input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron <input type="checkbox"/> Gilenya <input type="checkbox"/> Glatiramer <input type="checkbox"/> Plegridy <input type="checkbox"/> Tecfidera
Q5. For AUBAGIO, please select all that apply to this patient: <input type="checkbox"/> Patient has severe hepatic impairment <input type="checkbox"/> Patient is currently being treated with leflunomide <input type="checkbox"/> Patient is pregnant



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Multiple Sclerosis-5 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Patient is a woman of child-bearing potential who is NOT using reliable contraception <input type="checkbox"/> None of the above	
<p>Q6. For GILENYA, please select all that apply to this patient:</p> <input type="checkbox"/> 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 <input type="checkbox"/> History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker <input type="checkbox"/> Baseline QTc interval greater than or equal to 500 ms <input type="checkbox"/> Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (such as quinidine, procainamide, amiodarone, or sotalol) <input type="checkbox"/> None of the above	
<p>Q7. For GILENYA, will the patient be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q8. For GLATIRAMER, is the patient 18 years of age or older?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q9. Please indicate the patient's diagnosis for the requested medication:</p> <input type="checkbox"/> Multiple sclerosis (relapsing forms) <input type="checkbox"/> First clinical episode and patient has MRI features consistent with multiple sclerosis <input type="checkbox"/> Other	
<p>Q10. If the patient's diagnosis is OTHER, please specify below:</p> 	

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Natpara-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Hypocalcemia due to hypoparathyroidism <input type="checkbox"/> Other
Q4. If diagnosis is OTHER, please specify:
Q5. Is the Prescriber certified in the NATPARA REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Natpara-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nerlynx-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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 (early stage HER2-overexpressed) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Will Nerlynx be used in a patient who has been previously treated with trastuzumab-based 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. Is Nerlynx prescribed by (or in consultation with) an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nerlynx-3 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ninlaro-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For continuing therapy, please specify start date (MM/YY).
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Other
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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Has the patient received at least one (1) prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the patient 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the medication prescribed by or in consultation with a hematologist/oncologist?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ninlaro-4 Medicare

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Neurogenic orthostatic hypotension (NOH) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. If the patient has a diagnosis of NOH, is the NOH due to any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Primary autonomic failure (Parkinson's disease, multiple system atrophy, or 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>
<p>Q6. If the patient has NOH that is NOT caused by any of the issues listed in the previous question, please specify the cause of the patient's NOH:</p>
<p>Q7. Does the patient have any of the following symptoms (please select all that apply)?</p> <p><input type="checkbox"/> Orthostatic dizziness</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-1 Medicare

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

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

Patient Name:

Prescriber Name:

- Lightheadedness
- "Feeling that you are about to black out"
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Severe asthma (Add-on maintenance treatment)</p> <p><input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis (EGPA)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For ASTHMA, does the patient have an eosinophilic phenotype?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Is the patient 12 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 a pulmonologist or immunologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-1 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify 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>

Prescriber Signature

Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuedexta-1 Medicare

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

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

Patient Name:

Prescriber Name:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuplazid-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Parkinson's disease - Psychotic disorder <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>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nuplazid-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Octreotide-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the diagnosis for which Octreotide is being requested:</p> <p><input type="checkbox"/> Acromegaly</p> <p><input type="checkbox"/> Metastatic carcinoid tumors</p> <p><input type="checkbox"/> Watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Octreotide-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:
Opsumit-6 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify 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) (World Health Organization group 1) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has diagnosis been confirmed by right heart catheterization?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For FEMALE PATIENTS, please select all that apply:</p> <p><input type="checkbox"/> The patient is enrolled in the OPSUMIT REMS program</p> <p><input type="checkbox"/> The patient is NOT pregnant</p> <p><input type="checkbox"/> The patient will use an IUD or two appropriate contraceptive methods</p> <p><input type="checkbox"/> N/A - The patient is not female or not of child-bearing potential</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opsumit-6 Medicare

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

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

Patient Name:

Prescriber Name:

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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. For CONTINUING THERAPY, is the patient tolerating and responding to the medication as evidenced by the following (please select all that apply)?</p> <p><input type="checkbox"/> Improved FEV1</p> <p><input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> Decreased exacerbations</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> None of the above</p>
<p>Q4. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Cystic Fibrosis (CF) <input type="checkbox"/> Other</p>
<p>Q5. If diagnosis is OTHER, please specify below:</p>
<p>Q6. Is the patient homozygous for the F508del mutation in the CFTR gene as confirmed by an FDA-approved CF test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orkambi-1 Medicare

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

Patient Name:

Prescriber Name:

Q7. Is the medication prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation?

Yes

No

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Endometriosis (with moderate to severe pain) <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"/> Current 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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Osphena-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Dyspareunia (moderate to severe) <input type="checkbox"/> Atrophic vaginitis <input type="checkbox"/> Moderate to severe vaginal dryness due to menopause <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient's condition caused by menopause? <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"/> Acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT,



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Patient Name:

Prescriber Name:

pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction)

- Known or suspected estrogen-dependent neoplasia
- Known or suspected pregnancy
- Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin
- None of the above

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Oxandrolone-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> To promote weight gain (adjunct therapy) <input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify below:</p>
<p>Q5. Does the patient have any of the following exclusions? (Please select all that apply):</p> <p><input type="checkbox"/> Known or suspected carcinoma of the prostate or breast (in male patients)</p> <p><input type="checkbox"/> Carcinoma of the breast in a female patient with hypercalcemia</p> <p><input type="checkbox"/> Nephrosis (the nephrotic phase of nephritis)</p> <p><input type="checkbox"/> Hypercalcemia</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

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Oxandrolone-1 Medicare

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Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Oxervate-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Neurotrophic keratitis <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the medication being prescribed by or in consultation with an ophthalmologist or optometrist? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
PCSK9 Inhibitors-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify the start date (MM/YY):</p>
<p>Q3. Please indicate which medication this request is for:</p> <p><input type="checkbox"/> Praluent <input type="checkbox"/> Repatha</p>
<p>Q4. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Heterozygous familial hypercholesterolemia (HeFH)</p> <p><input type="checkbox"/> Homozygous familial hypercholesterolemia (HoFH)</p> <p><input type="checkbox"/> Clinical atherosclerotic cardiovascular disease (CVD)</p> <p><input type="checkbox"/> Established CVD (to reduce the risk of MI, stroke, coronary revascularization)</p> <p><input type="checkbox"/> Other</p>
<p>Q5. For HeFH, has the diagnosis been confirmed by either of the following?</p> <p><input type="checkbox"/> Genotyping</p> <p><input type="checkbox"/> Simon Broome criteria</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. For HeFH, if the diagnosis was confirmed by Simon Broome criteria, please select all that apply to this patient:</p> <p><input type="checkbox"/> Total cholesterol greater than 290 mg/dL</p>



COVERAGE DETERMINATION REQUEST FORM

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PCSK9 Inhibitors-1 Medicare

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> LDL cholesterol greater than 190 mg/dL <input type="checkbox"/> Tendon xanthomas in the patient, 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt) <input type="checkbox"/> DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation <input type="checkbox"/> None of the above	
Q7. For HoFH, has the diagnosis been confirmed by any of the following? (please select all that apply): <input type="checkbox"/> Genotyping <input type="checkbox"/> History of untreated LDL-C greater than 500 mg/dL <input type="checkbox"/> Xanthoma before 10 years of age <input type="checkbox"/> Documentation of HeFH in both parents <input type="checkbox"/> None of the above	
Q8. For CVD, has the patient experienced any of the following (please select all that apply)? <input type="checkbox"/> Acute coronary syndrome <input type="checkbox"/> History of myocardial infarction <input type="checkbox"/> Stable or unstable angina <input type="checkbox"/> Coronary or other arterial revascularization <input type="checkbox"/> Stroke <input type="checkbox"/> Transient ischemic attack (TIA) <input type="checkbox"/> Peripheral arterial disease (PAD) presumed to be atherosclerotic region <input type="checkbox"/> None of the above	
Q9. If the patient's diagnosis is OTHER, please specify below:	
Q10. Please provide the patient's baseline and current LDL-C cholesterol levels below:	
Q11. Please indicate the patient's age: <input type="checkbox"/> Less than 13 years of age <input type="checkbox"/> 13-17 years of age <input type="checkbox"/> 18 years of age or older	
Q12. Please select all that apply to this patient: <input type="checkbox"/> Patient's LDL-C level is greater than or equal to 70 mg/dL <input type="checkbox"/> The requested medication will be used in combination with maximally tolerated high-intensity statin therapy <input type="checkbox"/> Statins are contraindicated or not tolerated by the patient <input type="checkbox"/> None of the above	
Q13. If statins are contraindicated or not tolerated by the patient, please explain below:	



COVERAGE DETERMINATION REQUEST FORM

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PCSK9 Inhibitors-1 Medicare

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Patient Name:

Prescriber Name:

Q14. Is the medication being prescribed by (or in consultation with) any of the following?

- Cardiologist
- Endocrinologist
- Lipid specialist
- None of the above

Q15. For CONTINUING THERAPY, please select all that apply to this patient:

- The patient is tolerating the medication
- The requested medication will continue to be used in combination with maximally tolerated statin
- Statin therapy is contraindicated or not tolerated by the patient
- None of the above

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pegasys-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For continuing therapy, please specify start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: * <input type="checkbox"/> Chronic Hepatitis B <input type="checkbox"/> Chronic Hepatitis C <input type="checkbox"/> Other
Q4. For CHRONIC HEPATITIS C, please indicate the patient's genotype below:
Q5. For CHRONIC HEPATITIS C, is the patient treatment naive or experienced? <input type="checkbox"/> Treatment naive (i.e. no previous treatment for Hepatitis C) <input type="checkbox"/> Treatment experienced (i.e. has received treatment for Hepatitis C in the past)
Q6. For CHRONIC HEPATITIS C, if the patient is treatment-experienced, please list all previous treatment regimens as well as the response to the regimen (i.e. non-responder, relapser, etc):
Q7. For CHRONIC HEPATITIS C, will Pegasys be used in conjunction with Sovaldi? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. If the patient's diagnosis is OTHER, please specify below:



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pegasys-2 Medicare

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

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Patient Name:	Prescriber Name:
Q9. Does the patient have any of the following? (please select all that apply): <input type="checkbox"/> Decompensated liver disease <input type="checkbox"/> Autoimmune hepatitis <input type="checkbox"/> Concomitant administration of didanosine with ribavirin in patients co-infected with HIV <input type="checkbox"/> None of the above	
Q10. Please select the prescriber's specialty: <input type="checkbox"/> Infectious disease (ID) <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Oncology <input type="checkbox"/> Other	
Q11. If the prescriber specialty is Other, please describe below:	
Q12. Will the patient be monitored for evidence of depression? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Please indicate the patient's age below: <input type="checkbox"/> 0 to 2 years <input type="checkbox"/> 3 - 4 years old <input type="checkbox"/> 5-17 years <input type="checkbox"/> 18 years old or older	

Prescriber Signature

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Pomalyst-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 Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis below:</p> <p><input type="checkbox"/> Multiple myeloma, in combination with dexamethasone <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 this patient:</p> <p><input type="checkbox"/> Patient has received at least two (2) prior therapies including lenalidomide (Revlimid) and a proteasome inhibitor (bortezomib (Velcade))</p> <p><input type="checkbox"/> Disease has progressed within 60 days of completion of the last therapy</p> <p><input type="checkbox"/> Patient has been counseled about the use of reliable contraception before, during and 1 month after initiation of therapy</p> <p><input type="checkbox"/> Patient has been assessed to determine if prophylactic aspirin or antithrombotic treatment (warfarin, clopidogrel) will need to be taken to reduce the risk of VTE (embolism, stroke)</p> <p><input type="checkbox"/> Patient is registered and certified to be compliant with Pomalyst REMS (Risk Evaluation and Mitigation Strategy) program</p> <p><input type="checkbox"/> None of the above</p>



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Pomalyst-1 Medicare

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Patient Name:

Prescriber Name:

Q6. For FEMALES OF CHILD-BEARING POTENTIAL, please select all that apply:

- Two (2) negative pregnancy tests have been obtained prior to initiation of therapy
- Patient will receive pregnancy test monthly during therapy
- Patient is male or not of reproductive potential
- None of the above

Q7. Please indicate the prescriber's specialty below:

- Oncologist Hematologist Other

Q8. If the answer is OTHER, please specify:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Promacta-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<p>Q1. Is 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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the diagnosis for which the requested medication is being prescribed:</p> <p><input type="checkbox"/> Idiopathic thrombocytopenic purpura (ITP)</p> <p><input type="checkbox"/> Hepatitis C infection associated thrombocytopenia</p> <p><input type="checkbox"/> Severe aplastic anemia with insufficient response to immunosuppressive therapy or in combination with immunosuppressive therapy</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 an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the platelet (Plt) count at time of diagnosis: less than 30,000/mcL OR less than or equal to 50,000/mcL with significant mucous membrane bleeding or risk factors for bleeding?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Promacta-3 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Will liver function be assessed pretreatment and regularly throughout therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Are alanine aminotransferase levels greater than or equal to 3 times the upper limit of normal with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. For CONTINUING therapy: Has the platelet count responded to Promacta? (Response defined as: Platelet count has increased to at least 50,000/mcL) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. For CONTINUING therapy and patient's platelet count less than 50,000/microliter: Has platelet count increased to a level sufficient to avoid clinically important bleeding after at least 4 weeks of Promacta at the maximum dose? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. For CONTINUING therapy: If platelet counts rise above 200,000/mcL with Promacta, will therapy be adjusted to maintain the minimal count needed to reduce the patient's risk for bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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 below: <input type="checkbox"/> Diabetic neuropathic ulcer <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Will treatment be given in combination with ulcer wound care (such as debridement, infection control, and/or pressure relief)? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Regranex-1 Medicare

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Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revlimid-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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: *</p> <p><input type="checkbox"/> Mantle cell lymphoma</p> <p><input type="checkbox"/> Multiple Myeloma</p> <p><input type="checkbox"/> Transfusion-dependent anemia</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For MANTLE CELL LYMPHOMA, has the patient relapsed or progressed after two (2) prior therapies (one of which included bortezomib)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. For MULTIPLE MYELOMA, please select all that apply:</p> <p><input type="checkbox"/> Revlimid will be used in combination with dexamethasone <input type="checkbox"/> None of the above</p>
<p>Q6. For TRANSFUSION-DEPENDENT ANEMIA, is the condition due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revlimid-3 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. If the patient's diagnosis is OTHER, please specify below:	
Q8. Is the patient enrolled in the Revlimid REMS Program?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient pregnant?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Have male and female patients of child-bearing potential been instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Will the patient be monitored for signs and symptoms of thromboembolism?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Epithelial ovarian, fallopian tube, or primary peritoneal cancer (deleterious germline and/or somatic BRCA mutation associated)</p> <p><input type="checkbox"/> Epithelial ovarian, fallopian tube, or primary peritoneal cancer (recurrent)</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 Rubraca being prescribed by a hematologist or oncologist?</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 BRCA mutation positive as detected by an approved FDA laboratory test</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rubraca-1 Medicare

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

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

Patient Name:

Prescriber Name:

- The patient has had previous trial and failure with two or more chemotherapy regimens
- The patient has had a complete or partial response to platinum-based chemotherapy
- Rubraca will be used as monotherapy
- The provider agrees to perform a complete blood count (CBC) at baseline and monthly thereafter
- None of the above

Q8. For WOMEN OF REPRODUCTIVE POTENTIAL, will an effective method of contraception be used during therapy and for 6 months after the last dose?

- Yes
- No
- N/A - The patient is not a female of reproductive potential

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Acute myeloid leukemia (AML), newly diagnosed</p> <p><input type="checkbox"/> Mast cell leukemia (MCL)</p> <p><input type="checkbox"/> Systemic mastocytosis</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For ACUTE MYELOID LEUKEMIA, please select which of the following (if any) apply to this patient:</p> <p><input type="checkbox"/> The patient is treatment naïve</p> <p><input type="checkbox"/> The patient is FLT3 mutation-positive</p> <p><input type="checkbox"/> Rydapt will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy</p> <p><input type="checkbox"/> None of the above</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Is the patient 18 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rydapt-1 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the patient have angioedema? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Samsca-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is the request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For continuing therapy, please specify start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Hypervolemic hyponatremia <input type="checkbox"/> Euvolemic hyponatremia <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have anuria? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Does the patient require an URGENT increase in serum sodium? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the patient able to sense and respond to thirst? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Samsca-2 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Will Samsca be used in combination with a strong CYP3A inhibitor (such as clarithromycin or ketoconazole)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Will Samsca be initiated or re-initiated in a hospital where serum sodium can be monitored closely?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sildenafil-5 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify 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) (WHO Group I) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has PAH been confirmed by right heart catheterization or by 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>
<p>Q6. Is the patient currently on nitrate therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sildenafil-5 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somatuline-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Acromegaly</p> <p><input type="checkbox"/> Unresectable, well- or moderately-differentiated, locally advanced or metastatic carcinoid gastroenteropancreatic neuroendocrine tumor</p> <p><input type="checkbox"/> Hyperthyroidism secondary to thyrotropinoma</p> <p><input type="checkbox"/> Carcinoid syndrome</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If diagnosis is ACROMEGALY, please check all that apply:</p> <p><input type="checkbox"/> Patient has had an inadequate response to surgery and/or radiotherapy</p> <p><input type="checkbox"/> Surgery and/or radiotherapy is not an option for this patient</p> <p><input type="checkbox"/> None of the above</p>
<p>Q5. If diagnosis is OTHER, please specify.</p>
<p>Q6. Is the patient 18 years of age or older?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somatuline-3 Medicare

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somavert-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Acromegaly, Second-line therapy <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the diagnosis of acromegaly been confirmed by an elevated IGF-1 level or elevated GH level with a glucose tolerance test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Has the patient tried and failed a 3 month trial of Sandostatin or Somatuline? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Is the medication being prescribed by an endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Will Somavert be administered IV?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somavert-2 Medicare

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

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

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Will the patient also be using Sandostatin or Somatuline while on Somavert therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. FOR CONTINUING THERAPY, has the patient experienced a reduction in IGF-1 level from baseline?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify 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) in chronic phase, Philadelphia chromosome-positive (Ph+) [newly diagnosed]</p> <p><input type="checkbox"/> Chronic myeloid leukemia (CML) in chronic, accelerated, myeloid or lymphoid blast phase, Philadelphia chromosome-positive (Ph+)</p> <p><input type="checkbox"/> Acute lymphoblastic leukemia (ALL), Philadelphia chromosome-positive (Ph+)</p> <p><input type="checkbox"/> Newly diagnosed Ph+ Acute lymphoblastic leukemia (ALL) in combination with chemotherapy</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 resistance or intolerance to prior therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If yes, did the prior therapy include imatinib (Gleevec)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sprycel-1 Medicare

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

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

Patient Name:

Prescriber Name:

Q7. Is the medication being prescribed by an oncologist?

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-5 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 specify 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)</p> <p><input type="checkbox"/> Gastrointestinal stromal tumors (GIST) (locally advanced, unresectable or metastatic)</p> <p><input type="checkbox"/> Hepatocellular carcinoma (previously treated with sorafenib [Nexavar])</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For COLORECTAL CANCER, is the patient's disease KRAS mutation negative?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. For COLORECTAL CANCER, please indicate which of the following the patient has previously tried (please select all that apply):</p> <p><input type="checkbox"/> Fluoropyrimidine-, oxaliplatin, and irinotecan-based chemotherapy</p> <p><input type="checkbox"/> Bevacizumab (Avastin)</p> <p><input type="checkbox"/> Panitumumab (Vectibix)</p> <p><input type="checkbox"/> Cetuximab (Erbix)</p> <p><input type="checkbox"/> Other</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-5 Medicare

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

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

Patient Name:	Prescriber Name:
Q6. If medication is Other, please specify:	
Q7. For GASTROINTESTINAL STROMAL TUMORS, please select which of the following the patient has previously tried (please select all that apply): <input type="checkbox"/> Imatinib mesylate (Gleevec) <input type="checkbox"/> Sunitinib malate (Sutent) <input type="checkbox"/> Other	
Q8. If OTHER, please specify:	
Q9. If the patient's diagnosis is OTHER, please specify below:	
Q10. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is the requested medication being prescribed by an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sutent-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 below: *</p> <p><input type="checkbox"/> Progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease</p> <p><input type="checkbox"/> Renal cell carcinoma, advanced/metastatic</p> <p><input type="checkbox"/> Gastrointestinal stromal tumor</p> <p><input type="checkbox"/> Adjuvant treatment in renal cell carcinoma for patients at high risk of recurrence following nephrectomy</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify.</p>
<p>Q5. For GASTROINTESTINAL STROMAL TUMORS, has the patient had disease progression on or intolerance to Gleevec (imatinib)?</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>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sutent-4 Medicare

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

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

Patient Name:

Prescriber Name:

Q7. Is the medication prescribed by an oncologist?

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sylatron-2 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 below:</p> <p><input type="checkbox"/> Malignant Melanoma with microscopic or gross nodal involvement <input type="checkbox"/> Other</p>
<p>Q4. If the diagnosis is OTHER, please specify:</p>
<p>Q5. Does the patient have any of the following (please select all that apply)?</p> <p><input type="checkbox"/> Autoimmune hepatitis</p> <p><input type="checkbox"/> Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])</p> <p><input type="checkbox"/> None of the above</p>
<p>Q6. For melanoma with microscopic or gross nodal involvement, is Sylatron being used as adjuvant treatment within 84 days of definitive surgical resection, including complete lymphadenectomy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Sylatron-2 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symdeko-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Cystic fibrosis <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"/> The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test</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:
Symdeko-3 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symlin-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For INITIAL THERAPY, does the patient have inadequate glycemic control (HbA1c greater than 7% but less than 9%)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q3. For CONTINUING THERAPY, please indicate the start date (MM/YY):
Q4. For CONTINUING THERAPY, has the patient taken Symlin in the previous 6 months and demonstrated a reduction in HbA1c since initiating Symlin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Diabetes mellitus (type 1 or type 2), adjunctive treatment <input type="checkbox"/> Other
Q6. If the patient's diagnosis is OTHER, please specify below:
Q7. Is the patient currently receiving optimal mealtime insulin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symlin-3 Medicare

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

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

Patient Name:

Prescriber Name:

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

- Gastroparesis
- Hypoglycemia unawareness (i.e. inability to detect and act upon the signs or symptoms of hypoglycemia)
- Severe hypoglycemia that required assistance during the past 6 months
- The patient requires drug therapy to stimulate gastrointestinal motility
- None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tafinlar-6 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Melanoma (unresectable or metastatic) in a patient with BRAF V600E mutation (single agent therapy)</p> <p><input type="checkbox"/> Melanoma (unresectable or metastatic) in patients with BRAF V600E or V600K mutation (in combination with trametinib [Mekinist])</p> <p><input type="checkbox"/> Non-small cell lung cancer, Metastatic with BRAF V600E mutation, in combination with trametinib</p> <p><input type="checkbox"/> Anaplastic thyroid carcinoma, Locally advanced or metastatic, with BRAF V600E mutation, in combination with trametinib</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 a positive BRAF V600E or V600K mutation as detected by an FDA-approved test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have wild-type BRAF melanoma?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tafinlar-6 Medicare

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

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

Patient Name:

Prescriber Name:

Q7. Is the requested medication being prescribed by an oncologist?

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tagrisso-4 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> 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. Was the patient's diagnosis confirmed by an FDA-approved test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Please select if any of the following apply to this patient:</p> <p><input type="checkbox"/> The disease is metastatic EGFR mutation-positive</p> <p><input type="checkbox"/> There is confirmed presence of T790M EGFR tumor mutation</p> <p><input type="checkbox"/> The patient's disease has progressed on or after EGFR tyrosine kinase inhibitor based therapy</p> <p><input type="checkbox"/> None of the above</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tagrisso-4 Medicare

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

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

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

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 (prophylaxis) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. 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:
Takhzyro-1 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Talzenna-3 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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 presence of a deleterious or suspected deleterious germline BRCA-mutation (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 requested medication prescribed by (or in consultation with) an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the patient 18 years of age or older?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Talzena-3 Medicare

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

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

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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tasigna-5 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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"/> Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase (newly diagnosed)</p> <p><input type="checkbox"/> Chronic phase (CP) and accelerated phase (AP) Ph+ CML</p> <p><input type="checkbox"/> Other</p>
<p>Q4. Is the patient resistant to or intolerant to prior therapy ?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Is the requested medication being prescribed by an oncologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tasigna-5 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tegsedi-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy? <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"/> Polyneuropathy of hereditary transthyretin-mediated amyloidosis <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. Is the patient enrolled in the Tegsedi REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Do any of the following apply to the patient (please check all that apply)? <input type="checkbox"/> Platelet count is below 100 x 10(9)/L <input type="checkbox"/> Documented history of acute glomerulonephritis caused by inotersen <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tegsedi-1 Medicare

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

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

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Testosterone-1 Medicare

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

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

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

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

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

<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 Start Date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis below:</p> <p><input type="checkbox"/> Hypogonadism <input type="checkbox"/> Deficiency or absence of endogenous testosterone <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Do any of the following apply to this patient (please select all that apply)?</p> <p><input type="checkbox"/> Patient is female <input type="checkbox"/> Patient has prostate cancer <input type="checkbox"/> Patient has breast cancer <input type="checkbox"/> None of the above</p>
<p>Q6. Please indicate the patient's testosterone level PRIOR to start of therapy:</p> <p><input type="checkbox"/> Total testosterone GREATER than 300 ng/dL, free or bioavailable testosterone GREATER than 5 ng/dL <input type="checkbox"/> Total testosterone LESS than 300 ng/dL, free or bioavailable testosterone LESS than 5 ng/dL</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Testosterone-1 Medicare

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

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

Patient Name:	Prescriber Name:
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<input type="checkbox"/> Absence of endogenous testosterone
<input type="checkbox"/> None of the above

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tetrabenazine-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. For continuing therapy, please specify start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: * <input type="checkbox"/> Chorea associated with Huntington disease <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have any of the following EXCLUSIONS (please select all that apply)? <input type="checkbox"/> Untreated or inadequately treated depression <input type="checkbox"/> Actively suicidal <input type="checkbox"/> History of hepatic disease <input type="checkbox"/> Concurrent use of MAO inhibitors <input type="checkbox"/> Concurrent use of reserpine (or it has been less than 20 days since reserpine was discontinued) <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tetrabenazine-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Thalomid-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Multiple myeloma, newly diagnosed <input type="checkbox"/> Acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum <input type="checkbox"/> Severe erythema nodosum leprosum with cutaneous manifestations <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the requested medication being prescribed by an oncologist or infectious disease specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. If the diagnosis is multiple myeloma, will the patient receive concurrent dexamethasone? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. If the patient has a diagnosis of severe erythema nodosum leprosum and also has moderate to severe neuritis, will Thalomid be used as monotherapy?



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Thalomid-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> The patient does not have moderate to severe neuritis	
Q8. Will the patient be monitored for signs and symptoms of venous thromboembolism? <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	
Q10. Have male and female patients of child-bearing potential been instructed on the importance of proper utilization of appropriate contraceptive methods? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is the patient 12 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:
Tibsovo-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <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), relapsed or refractory <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the requested medication prescribed by (or in consultation with) an oncologist or hematologist? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tibsovo-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tracleer-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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"/> Pulmonary arterial hypertension (PAH) <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Has the diagnosis of PAH been confirmed by either of the following?</p> <p><input type="checkbox"/> Right heart catheterization <input type="checkbox"/> Doppler echocardiogram (if patient is unable to undergo a right heart catheterization) <input type="checkbox"/> None of the above</p>
<p>Q6. Does the patient have World Health Organization (WHO) Group 1 and New York Heart Association (NYHA) Functional Class II-IV symptoms?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. FOR FEMALE PATIENTS OF CHILD-BEARING POTENTIAL, has pregnancy been excluded prior to therapy and patient will use two forms of reliable contraception during therapy?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tracleer-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A - patient is not a female of child-bearing potential	
Q8. Does the patient have aminotransferase elevations accompanied by signs or symptoms of liver dysfunction or injury or bilirubin at least 2 times the upper limit of normal (ULN)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Will the patient be receiving concomitant cyclosporine A or glyburide therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tymlos-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Is the patient a post-menopausal female at high risk for fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the patient at least 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Has the patient experienced a prior fragility fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Does the patient have any of the following risk factors for fracture (please select all that apply)? <input type="checkbox"/> Advanced age <input type="checkbox"/> Rheumatoid arthritis



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tymlos-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
<input type="checkbox"/> Parental history of fracture <input type="checkbox"/> Low body mass index (BMI) <input type="checkbox"/> Current smoker <input type="checkbox"/> Chronic alcohol use	<input type="checkbox"/> Chronic steroid use <input type="checkbox"/> Other secondary cause of osteoporosis <input type="checkbox"/> None of the above
Q9. Has the patient failed an adequate trial of a bisphosphonate (one year) or has a contraindication or intolerance to a bisphosphonate trial? <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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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"/> Pulmonary arterial hypertension (PAH) (WHO Group I) <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 right heart catheterization?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has the patient tried and had an insufficient response to at least one other PAH agent (e.g. sildenafil)?</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

EOC ID:
Uptravi-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Venclexta-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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"/> Acute myeloid leukemia (AML), newly diagnosed</p> <p><input type="checkbox"/> Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (with or without 17p deletion)</p> <p><input type="checkbox"/> Other</p>
<p>Q4. For NEWLY DIAGNOSED AML, please select all that apply to this patient:</p> <p><input type="checkbox"/> The patient is 75 years of age or older</p> <p><input type="checkbox"/> The patient cannot use intensive induction chemotherapy</p> <p><input type="checkbox"/> Venclexta will be used in combination with azacitadine, decitabine, or low-dose cytarabine</p> <p><input type="checkbox"/> None of the above</p>
<p>Q5. For CLL/SLL, has the patient received at least one (1) prior therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. If the patient's diagnosis is OTHER, please specify below:</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Venclexta-6 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:
Verzenio-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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"/> 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. For BREAST CANCER, please select all that apply to this patient's disease:</p> <p><input type="checkbox"/> The patient's disease is hormone receptor (HR)-positive <input type="checkbox"/> The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative <input type="checkbox"/> None of the above</p>
<p>Q6. For BREAST CANCER, please select all that apply to this patient's treatment:</p> <p><input type="checkbox"/> Verzenio will be used as monotherapy <input type="checkbox"/> Verzenio will be used in combination with fulvestrant (Faslodex) <input type="checkbox"/> Verzenio will be used as initial endocrine-based treatment in combination with an aromatase inhibitor <input type="checkbox"/> The patient's disease has progressed following endocrine therapy <input type="checkbox"/> The patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verzenio-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
<input type="checkbox"/> None of the above	
Q7. Is the medication being prescribed by (or in consultation with) an oncologist?	
<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

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vitrakvi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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"/> Solid tumor <input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the patient's tumor neurotrophic receptor tyrosine kinase (NTRK) gene fusion positive without a known acquired resistance mutation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Please select all that apply to this patient:</p> <p><input type="checkbox"/> The patient's disease is metastatic, or surgical resection is likely to result in severe morbidity</p> <p><input type="checkbox"/> There is no satisfactory alternative treatment (or the patient has progressed following treatment)</p> <p><input type="checkbox"/> None of the above</p>
<p>Q7. Is the requested medication being 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:

Vitrakvi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vizimpro-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <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 positive for epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutations as detected by an FDA approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is the medication being prescribed by (or in consultation with) an oncologist? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vizimpro-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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 diagnosis for which the requested medication is being prescribed:</p> <p><input type="checkbox"/> Non-small cell lung cancer, Metastatic, ALK-positive</p> <p><input type="checkbox"/> Non-small cell lung cancer, Metastatic, ROS1-positive</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If diagnosis is OTHER, please specify below:</p>
<p>Q5. Is the prescribing physician 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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xeljanz-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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"/> Rheumatoid arthritis (moderately to severely active)</p> <p><input type="checkbox"/> Psoriatic Arthritis</p> <p><input type="checkbox"/> Ulcerative Colitis</p> <p><input type="checkbox"/> Other</p>
<p>Q4. FOR Ulcerative Colitis: Is the patient corticosteroid dependent (ie, an inability to successfully taper corticosteroids without a return of the symptoms of UC)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q6. Has the patient had failure, contraindication, or intolerance to any of the following? (please select all that apply):</p> <p><input type="checkbox"/> Methotrexate</p> <p><input type="checkbox"/> Enbrel (etanercept)</p> <p><input type="checkbox"/> Humira (adalimumab)</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xeljanz-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
<input type="checkbox"/> Oral aminosalicilate <input type="checkbox"/> Oral corticosteroid <input type="checkbox"/> Azathioprine <input type="checkbox"/> 6-mercaptopurine <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 these medications cannot be used (i.e. contraindication, history of adverse event, etc)?	
Q8. Does the patient have a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure? (refer to DSM-IV-TR 300.29 for specific phobia diagnostic criteria) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Will the patient be receiving any of the following while taking Xeljanz? <input type="checkbox"/> A biologic DMARD (such as Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)) <input type="checkbox"/> A potent immunosuppressant (such as azathioprine or cyclosporine) <input type="checkbox"/> None of the above	
Q10. Is the requested medication prescribed by (or in consultation with) a rheumatologist or gastroenterologist? <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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication:</p> <p><input type="checkbox"/> Bone metastases from solid tumors</p> <p><input type="checkbox"/> Giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity</p> <p><input type="checkbox"/> Hypercalcemia of malignancy refractory to bisphosphonate therapy</p> <p><input type="checkbox"/> Prevention of skeletal related events in patients with multiple myeloma</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 uncorrected hypocalcemia?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xgeva-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Xolair-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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. What is the patient's diagnosis for the requested medication? *</p> <p><input type="checkbox"/> Chronic idiopathic urticaria</p> <p><input type="checkbox"/> Moderate to severe persistent allergic asthma</p> <p><input type="checkbox"/> Other</p>
<p>Q4. FOR URTICARIA, does the patient remain symptomatic despite H1 antihistamine treatment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. FOR CONTINUING THERAPY: Has a demonstrated improvement in asthma control been noted?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. FOR ASTHMA, please select all that apply to this patient:</p> <p><input type="checkbox"/> Patient has evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen</p> <p><input type="checkbox"/> Pretreatment serum IgE levels are greater than 30 and less than 1300 IU/mL</p> <p><input type="checkbox"/> Patient's symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months OR member has documented intolerance to ICS or LABA OR member</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xospata-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <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, relapsed or refractory <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Are FLT3 mutations present as detected by an 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 medication being prescribed by (or in consultation with) an oncologist or hematologist? <input type="checkbox"/> Yes <input type="checkbox"/> No



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Xospata-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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 below: <input type="checkbox"/> Prostate Cancer (metastatic, castration-resistant) <input type="checkbox"/> Prostate Cancer (non-metastatic, castration-resistant) <input type="checkbox"/> Other
Q4. FOR Metastatic prostate cancer: Has the patient tried and failed Zytiga? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. If the patient has not tried Zytiga, is there a reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?
Q6. If diagnosis is OTHER, please specify below:
Q7. Please indicate the Prescriber's specialty: <input type="checkbox"/> Oncologist <input type="checkbox"/> Urologist <input type="checkbox"/> None of the above



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Q8. Is the patient 18 years of age or older?

Yes

No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xuriden-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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



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:

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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 specify start date (MM/YY):</p>
<p>Q3. Please indicate the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> Excessive daytime sleepiness</p> <p><input type="checkbox"/> Cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy</p> <p><input type="checkbox"/> Other</p>
<p>Q4. If the patient's diagnosis is OTHER, please specify below:</p>
<p>Q5. Is that patient taking or receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines, or ethanol?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. For CONTINUING THERAPY, has the patient experienced a decrease in daytime sleepiness and/or cataplexy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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"/> Prostate Cancer (metastatic, castration-resistant) <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 in combination with methylprednisolone?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has the patient tried and failed (or has an intolerance or contraindication to) Zytiga (abiraterone)?</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>
<p>Q8. Is the medication being prescribed by (or in consultation with) an oncologist or urologist?</p>



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Yonsa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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: <input type="checkbox"/> Ovarian cancer (recurrent, epithelial) <input type="checkbox"/> Fallopian tube cancer (recurrent) <input type="checkbox"/> Primary peritoneal cancer (recurrent) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Has the patient had a complete or partial response to platinum-based chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Is Zejula being prescribed by (or in consultation with) an oncologist or gynecologist? <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



COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Prescriber Name:

Prescriber Signature

Date

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zykadia-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

***Please note that Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<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. What is the patient's diagnosis for the requested medication: *</p> <p><input type="checkbox"/> Anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) <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:
Zytiga-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 Envision will process the request as written, including drug name, with no substitution.**

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy
Q2. If the request is for CONTINUING THERAPY, please specify the start date (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication: <input type="checkbox"/> Metastatic prostate cancer (castration-resistant or high-risk castration-sensitive) <input type="checkbox"/> Other
Q4. If the patient's diagnosis is OTHER, please specify below:
Q5. Will Zytiga be used combination with prednisone? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Patient Name:

Prescriber Name:

Prescriber Signature

Date

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