ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic granulomatous disease
☐ Malignant osteoporosis (severe)
☐ Other

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

Prescriber Signature

Date

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Actimmune-2 Medicare

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

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

ENVISIONRx

# 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): | |

***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 provide the start date (MM/YY):

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

☐ Chronic thromboembolic pulmonary hypertension (CTEPH) (World Health Organization group 4)
☐ Pulmonary arterial hypertension (PAH) (World Health Organization group 1)
☐ Other

Q4. For a diagnosis of CTEPH, please select all that apply:

☐ Patient has persistent or recurrent disease after surgical treatment (e.g. pulmonary endarterectomy)
☐ Patient's disease is inoperable
☐ None of the above

Q5. For a diagnosis of PAH, was the diagnosis confirmed by right heart catheterization?

☐ Yes ☐ No

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

Q7. If the patient is FEMALE, is she enrolled in the ADEMPAS REMS program?

ENVISIONRx

# 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:** |
|---|---|

- ☐ Yes
- ☐ No
- ☐ N/A - the patient is not female

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
ADHD-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?

☐ Initial therapy ☐ 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:

☐ Amphetamine-dextroamphetamine ER
☐ Daytrana Patch
☐ Dextroamphetamine ER
☐ Dextroamphetamine IR
☐ Methylphenidate
☐ Vyvanse

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Attention deficit disorder (ADD)
☐ Attention Deficit Hyperactivity disorder (ADHD)
☐ Narcolepsy
☐ Other

Q5. For NARCOLEPSY, have sleep studies been completed which support the diagnosis?

☐ Yes ☐ No

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
ADHD-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:** |
|---|---|

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

Q7. Please indicate the patient's age below:

☐ Under 3 years ☐ 3-5 years ☐ 6 years or older

Q8. Has the prescriber considered the benefits of use versus the potential risks of serious cardiovascular events?

☐ Yes ☐ No

Q9. Will the patient be using an MAOI concurrently with the requested medication, or within the last 14 days?

☐ Yes ☐ No

Q10. Is the prescriber a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

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

Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)- positive?

☐ Yes ☐ No

# 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:** |
|---|---|
| Prescriber Signature | Date |

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Alpha-1 Proteinase Inhibitor-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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Alpha-1-antitrypsin (AAT) deficiency ☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Please select all that apply for this patient:

☐ The alpha1-proteinase inhibitor concentration is less than 11 micromoles per liter
☐ The patient's FEV1 level is between 35% and 60% predicted
☐ The patient's FEV1 level is greater than 60% predicted
☐ None of the above

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?

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Alpha-1 Proteinase Inhibitor-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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q8. Does the patient have IgA deficiency with antibodies against IgA? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

Q4. For NSCLC, is the patient anaplastic lymphoma kinase (ALK)-positive?
☐ Yes ☐ 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)?
☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

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

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Ambrisentan-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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH), WHO Group I ☐ 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.)?

☐ Yes ☐ No

Q6. Is the patient pregnant?

☐ Yes ☐ No

Q7. For FEMALE PATIENTS OF CHILD-BEARING POTENTIAL, please select all that apply:

☐ Pregnancy has been excluded prior to the start of therapy

☐ The patient has been educated about the potential hazards associated with the use of this medication in pregnancy

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Ambrisentan-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:** |
|---|---|

- ☐ Women of childbearing potential will be using an IUD or two appropriate contraceptive methods
- ☐ None of the above
- ☐ N/A - The patient is not a female of child-bearing potential

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Ampyra-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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication: *
☐ Multiple sclerosis (MS) ☐ 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?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication being prescribed by (or in consultation with) a neurologist?
☐ Yes ☐ No

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

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Ampyra-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:** |
|---|---|

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

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Analeptics-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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate which medication this request is for:

☐ Armodafinil ☐ Modafinil

Q4. For MODAFINIL, is the patient 17 years of age or older?

☐ Yes ☐ No

Q5. Please indicate the patient's diagnosis for the requested medication: *

☐ Excessive sleepiness associate with narcolepsy
☐ Excessive sleepiness associated with shift work sleep disorder (SWSD)
☐ Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSA/HS)
☐ 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)?

☐ Yes ☐ No

Q7. For SWSD, please select all that apply to this patient:

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Analeptics-3 Medicare

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

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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

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Arcalyst-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?
☐ Initial therapy ☐ 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?
☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis for the requested medication:
☐ Cryopyrin-associated periodic syndrome (CAPS) ☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Is the patient 12 years of age or older?
☐ Yes ☐ No

Q7. Does the patient have any of the following (please select all that apply)?
☐ Active infection
☐ Chronic infection
☐ Concurrent therapy with other biologics
☐ None of the above

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Arcalyst-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

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Arikayce-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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary Mycobacterium avium complex (MAC) infection ☐ Other

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

Q5. Will Arikayce be used in combination with other antibacterial drugs?

☐ Yes ☐ No

Q6. Has the patient been treated for 6 consecutive months with multidrug background regimen therapy?

☐ Yes ☐ No

Q7. Has the patient achieved negative sputum cultures from prior treatment?

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Arikayce-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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q9. Is the requested medication being prescribed by (or in consultation with) an infectious disease specialist or pulmonologist? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate which medication this request is for:

☐ Fanapt ☐ Saphris ☐ Vraylar

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Bipolar I disorder (manic or mixed episodes)
☐ Dementia-related psychosis only
☐ Schizophrenia
☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Please indicate the patient's age below:

☐ Under 10 years of age
☐ 10-17 years of age
☐ 18-64 years of age
☐ 65 years of age or older

ENVISIONRx

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hyperphosphatemia
☐ Iron deficiency anemia
☐ Other

Q4. Does the patient have chronic kidney disease (CKD)?

☐ Yes ☐ No

Q5. Is the patient on dialysis?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chorea associated with Huntington's Disease
☐ Tardive Dyskinesia - medication-induced
☐ Other

Q4. For HUNTINGTON'S DISEASE, does the prescriber attest that patient has NOT taken an MAOI in the past 14 days?

☐ Yes ☐ No

Q5. For TARDIVE DYSKINESIA, does the patient have a history of using a dopamine receptor antagonist?

☐ Yes ☐ No

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

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

☐ Yes ☐ No

ENVISIONRx

# 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:** |
|---|---|

Q8. Is the requested medication being prescribed by (or in consultation with) a psychiatrist or neurologist?

☐ Yes ☐ No

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

- ☐ Any degree of hepatic impairment or hepatic disease
- ☐ Active suicidal ideation
- ☐ Untreated or inadequately treated depression
- ☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Balversa-12 Medicare

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

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Urothelial carcinoma, locally advanced or metastatic ☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by (or in consultation with) an oncologist or urologist?

☐ Yes ☐ No

Q7. Do any of the following apply to this patient (please select all that apply)?

☐ The patient has susceptible FGFR3 or FGFR2 genetic alterations

☐ The patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy

☐ None of the above

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Balversa-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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Bosentan-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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH) ☐ Other

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

Q5. Has the diagnosis of PAH been confirmed by either of the following?

☐ Right heart catheterization

☐ Doppler echocardiogram (if patient is unable to undergo a right heart catheterization [e.g., patient is frail, elderly, etc.] )

☐ None of the above

Q6. Does the patient have World Health Organization (WHO) Group 1 and New York Heart Association (NYHA) Functional Class II-IV symptoms?

☐ Yes ☐ No

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Bosentan-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. 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?

- ☐ Yes
- ☐ No
- ☐ 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)?

☐ Yes ☐ No

Q9. Will the patient be receiving concomitant cyclosporine A or glyburide therapy?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) (chronic, accelerated, or blast phase)
☐ Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) (newly diagnosed chronic phase)
☐ Other

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)?

☐ Gleevec (imatinib)
☐ Sprycel (dasatinib)
☐ Tasigna (nilotinib)
☐ None of the above

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)?

ENVISIONRx

# 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:** |
|---|---|

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

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Melanoma (unresectable or metastatic) ☐ Other

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

Q5. Does the patient have BRAF V600E or V600K mutation as detected by an FDA-approved test?
☐ Yes ☐ No

Q6. Will Braftovi be used in combination with Mektovi (binimetinib)?
☐ Yes ☐ No

Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist?
☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Cablivi-13 Medicare

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

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

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| 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 provide the start date (MM/YY):

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

☐ Thrombotic thrombocytopenic purpura, acquired (aTTP) ☐ Other

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

Q5. Is the patient 18 years of age and older?

☐ Yes ☐ No

Q6. Will the requested medication be used in combination with plasma exchange and immunosuppression therapy?

☐ Yes ☐ No

Q7. Please indicate the Prescriber's specialty:

☐ Hematologist ☐ Oncologist ☐ None of the above

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Cablivi-13 Medicare

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

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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Renal cell carcinoma (advanced) ☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

# 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 |

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Mantle cell lymphoma (MCL) ☐ 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?

☐ Yes ☐ No

Q6. Is Calquence being prescribed by (or in consultation with) an oncologist?

☐ Yes ☐ No

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

☐ Yes ☐ 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):

Q3. For CONTINUING THERAPY, please select all that apply:

☐ The patient is benefitting from treatment (for example, improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

☐ There is clinical reason to continue therapy (such as symptomatic improvement or pulmonary function tests have not deteriorated more than 10% from baseline)

☐ None of the above

Q4. Please indicate that patient's diagnosis for the requested medication:

☐ Cystic fibrosis (CF) ☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Has the diagnosis been confirmed by appropriate diagnostic or genetic testing?

☐ Yes ☐ No

Q7. Does the patient have evidence of P. aeruginosa in the lungs as confirmed by cultures of the airways?

ENVISIONRx

# 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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q8. Is the patient 7 years of age or older? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), relapsed or refractory
☐ Follicular lymphoma, relapsed or refractory
☐ Other

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

Q5. Has the patient been treated with at least 2 prior therapies?

☐ Yes ☐ No

Q6. Is the requested medication being prescribed by (or in consultation with) an oncologist or hematologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic heart failure (stable, symptomatic)

☐ Stable, symptomatic heart failure due to dilated cardiomyopathy in patients who are in sinus rhythm with an elevated heart rate

☐ Other

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

Q5. Is the patient's left ventricular ejection fraction (LVEF) 35% or less?

☐ Yes ☐ No

Q6. Is the patient in sinus rhythm with resting heart rate of 70 beats per minute or more?

☐ Yes ☐ No

Q7. Is the patient on maximally tolerated doses of beta blockers OR has a contraindication to beta blocker use?

☐ Yes ☐ No

ENVISIONRx

# 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:** |
|---|---|

Q8. 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. For CONTINUING THEARPY, is there documentation that the patient has had a positive clinical response to Cosentyx therapy?

☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Ankylosing spondylitis (active)
☐ Plaque psoriasis (moderate to severe)
☐ Psoriatic arthritis (active)
☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

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

☐ Enbrel ☐ Humira ☐ None of the above

ENVISIONRx

# 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:** |
|---|---|

Q7. Will the patient be using Cosentyx in combination with any of the following (please select all that apply)?

- ☐ A biologic DMARD (such as Enbrel, Humira, Cimzia, or Simponi)
- ☐ A Janus kinase inhibitor (such as Xeljanz)
- ☐ None of the above

Q8. For PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS, will the patient be using Cosentyx in combination with a phosphodiesterase 4 (PDE4) inhibitor (such as Otezla)?

☐ Yes ☐ No

Q9. Please indicate the prescriber's specialty below:

☐ Dermatologist ☐ Rheumatologist ☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Melanoma (unresectable or metastatic) ☐ Other

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

Q5. Does the patient have BRAF V600E or V600K mutation?
☐ Yes ☐ No

Q6. Will the requested medication be used in combination with vemurafenib (Zelboraf)?
☐ Yes ☐ 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystinosis ☐ Other

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

Q5. Does the patient have corneal crystal accumulation?

☐ Yes ☐ No

# 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 |

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia (newly diagnosed) ☐ 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?

☐ Yes ☐ No

Q6. Will Daurismo be used in combination with low-dose cytarabine?

☐ Yes ☐ No

Q7. Is the patient 75 years of age or older?

☐ Yes ☐ No

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

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY).

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

☐ Actinic keratosis ☐ Other

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

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:** |
|---|---|

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Anorexia associated with weight loss in a patient with AIDS
☐ Nausea and vomiting (N/V) associated with cancer chemotherapy
☐ Other

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?

☐ Yes ☐ No

Q5. FOR ANOREXIA: Has the patient failed to respond to a 30-day trial of megestrol (Megace)?

☐ Yes ☐ No

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?

☐ Yes ☐ No

ENVISIONRx

# 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?

☐ Yes ☐ 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?

☐ Yes ☐ No

Q9. FOR N/V: Has the patient had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron?

☐ Yes ☐ 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?

☐ Yes ☐ 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?

☐ Yes ☐ No

Q12. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Ankylosing spondylitis
☐ Plaque psoriasis (moderate to severe)
☐ Polyarticular juvenile idiopathic arthritis (moderate to severe)
☐ Psoriatic arthritis
☐ Rheumatoid arthritis (moderate to severe)
☐ Other

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

Q5. Do any of the following apply to this patient (please select all that apply)?

☐ The patient has an active serious infection (including tuberculosis)
☐ The patient will be using Enbrel with another biologic disease-modifying anti-rheumatic drug (DMARD)
☐ The patient will be using Enbrel with potent immunosuppressant (such as azathioprine or cyclosporine)
☐ None of the above

ENVISIONRx

# 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 _____

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Sickle cell disease (acute) ☐ Other

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

Q5. Has the patient tried and failed (or has an intolerance or contraindication to) hydroxyurea?

☐ Yes ☐ No

Q6. Is the patient 5 years of age or older?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Heart failure ☐ 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:

☐ NYHA Class I
☐ NYHA Class II
☐ NYHA Class III
☐ NYHA Class IV

Q6. Does the patient have any of the following EXCLUSIONS (please select all that apply)?

☐ Patient has history of angioedema related to previous ACE-inhibitor or ARB therapy
☐ Patient will be using Entresto concomitantly, or within 36 hours of an ACE-inhibitor
☐ Entresto will be used concomitantly with aliskiren (Tekturna) in a diabetic patient
☐ None of the above

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Severe myoclonic epilepsy in infancy
☐ Lennox-Gestaut syndrome (LGS)
☐ Other

Q4. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Is the requested medication being prescribed by (or in consultation with) a neurologist?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Prostate cancer (non-metastatic) ☐ Other

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

Q5. Is the patient's disease castration-resistant?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist or urologist?
☐ Yes ☐ No

Q8. Is the patient pregnant?
☐ Yes

ENVISIONRx

# 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:** |
|---|---|

- ☐ No
- ☐ N/A - The patient is not a female or not of child-bearing potential

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial therapy or continuing therapy? *

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Anemia associated with chronic kidney disease (CKD)
☐ Anemia associated with myelosuppressive chemotherapy
☐ Anemia associated with zidovudine therapy in a patient with HIV infection
☐ Reduction of blood transfusions in a patient undergoing elective, non-cardiac, non-vascular surgery
☐ Other

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

Q5. Is the patient's pre-treatment hemoglobin level less than 10 g/dL?

☐ Yes ☐ No

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)?

☐ Yes ☐ No

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Idiopathic pulmonary fibrosis (IPF) ☐ Other

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

Q5. Is the prescriber a pulmonologist?

☐ Yes ☐ No

Q6. Will the patient's hepatic function and liver function tests (LFTs) be monitored?

☐ Yes ☐ 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

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Multiple myeloma ☐ Other

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

Q5. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q6. Will Farydak be used in combination with bortezomib (Velcade) and dexamethasone?
☐ Yes ☐ No

Q7. Has the patient received at least two (2) prior regimens, including bortezomib (Velcade) and an immunomodulatory agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)]?
☐ Yes ☐ No

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

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Breakthrough cancer pain (in an opioid-tolerant patient) ☐ Other

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

Q5. Is the patient 16 years of age or older?

☐ Yes ☐ No

Q6. If the patient is taking any strong or moderate cytocyrome 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?

☐ Yes
☐ No
☐ N/A - Patient is not taking any strong CYP450 3A4 inhibitors

Q7. The plan has the following quantity limits in place: 120 lozenges per 30 days. Will the patient require a quantity

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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:** |
|---|---|

greater than this?

☐ Yes ☐ No

Q8. If the patient requires a quantity greater than specified above, please provide rationale for a quantity limit exception:

Prescriber Signature

Date

ENVISIONRx

# 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

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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:** |
|---|---|

(or Leukine) OR in patients at risk for infection-related complications

☐ 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?

☐ Yes ☐ No

Q7. Please indicate if any of the following apply to this patient (select all that apply):

☐ Administration within 24 hours preceding or following chemotherapy or radiotherapy

☐ E. coli hypersensitivity

☐ For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule beyond established regimens

☐ Treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle

☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Lambert-Eaton myasthenic syndrome (LEMS) ☐ Other

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

Q5. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q6. Does the patient have a history of seizures?
☐ Yes ☐ No

Prescriber Signature

Date

# 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:** |
|---|---|

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Fabry disease ☐ Other

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

Q5. Does the patient have an amenable galactosidase alpha gene (GLA) mutation?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non–small cell lung cancer (NSCLC), metastatic
☐ Non-small cell lung cancer (NSCLC), metastatic squamous (previously treated)
☐ Other

Q4. Has the patient's disease progressed following platinum-based chemotherapy?

☐ Yes ☐ 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?

☐ Yes ☐ No

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

☐ Yes ☐ No

ENVISIONRx

# 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:** |
|---|---|

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

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. 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)?

☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Parkinson disease ☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Please check all that apply to this patient:

☐ Patient is experiencing dyskinesia
☐ Patient is receiving levodopa based therapy
☐ Patient has tried and failed amantadine immediate release
☐ None of the above

Q7. Does the patient have end stage renal disease (ESRD) (CrCl below 15 mL/min/m2)?

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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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q8. Is the requested medication being prescribed by (or in consultation with) a neurologist? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

Q3. For CONTINUING THERAPY (ADULT PATIENTS), please select all that apply:

- ☐ Patient has seen clinical improvement
- ☐ IGF-1 will be monitored
- ☐ None of the above

Q4. Please indicate the patient's diagnosis for the requested medication:

- ☐ Growth failure in children
- ☐ Growth failure associated with chronic kidney disease (CKD)
- ☐ Growth failure associated with Noonan Syndrome
- ☐ Growth failure associated with Prader-Willi Syndrome
- ☐ Growth failure associated with short stature homeobox gene (SHOX) deficiency
- ☐ Growth failure or short stature associated with Turner Syndrome
- ☐ Growth failure in a pediatric patient born small for gestational age (SGA)
- ☐ Growth Hormone Deficiency (GHD) in neonates with hypoglycemia
- ☐ Growth Hormone Deficiency (GHD) in pediatrics
- ☐ Growth Hormone Deficiency (GHD) in adults
- ☐ Idiopathic short stature
- ☐ Other

ENVISIONRx

# 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:** |
|---|---|

Q5. For GROWTH FAILURE ASSOCIATED WITH CKD, please select all that apply:

- ☐ Metabolic, endocrine, and nutritional abnormalities have been treated or stabilized
- ☐ The patient has not had a kidney transplant
- ☐ None of the above

Q6. For GROWTH FAILURE ASSOCIATED WITH TURNER SYNDROME OR SHOX, has the diagnosis been confirmed by genetic testing?

☐ Yes ☐ No

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?

☐ Yes ☐ No

Q8. For GHD IN NEONATES WITH HYPOGLYCEMIA, please select all that apply:

- ☐ The patient has a randomly assessed growth hormone (GH) level less than 20 ng/mL
- ☐ Other causes of hypoglycemia have been ruled out
- ☐ Other treatments have been ineffective
- ☐ None of the above

Q9. For PEDIATRIC GHD, please select all that apply:

- ☐ The patient has delayed bone age
- ☐ The patient does not have pituitary disease, and has failed 2 stimulation tests
- ☐ The patient has pituitary or CNS disorder, and has clinical evidence of GHD and low IGF-1/IGFBP3
- ☐ None of the above

Q10. For ADULT GHD, please select all of the following that apply to this patient:

- ☐ The patient was assessed for other causes of GHD-like symptoms
- ☐ The patient does not have pituitary disease, and has failed 2 stimulation tests
- ☐ The patient has pituitary disease with at least 3 pituitary hormone deficiencies (PHD) or panhypopituitarism, and has low IGF-1
- ☐ The patient has pituitary disease with less than 3 PHD, has low IGF-1, and has failed 1 stimulation test
- ☐ None of the above

Q11. For IDIOPATHIC SHORT STATUTE, has pediatric GHD been ruled out with at least one (1) stimulation test?

☐ Yes ☐ No

Q12. If the patient's diagnosis is OTHER, please specify below:

Q13. Please select the prescriber's specialty below:

- ☐ Endocrinologist

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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:** |
|---|---|

- ☐ Gastroenterologist
- ☐ Infectious disease (ID) specialist
- ☐ Nutritional support specialist
- ☐ Pediatric nephrologist
- ☐ None of the above

Q14. Please indicate the patient's age below:

- ☐ Under 2 years of age
- ☐ 2-3 years of age
- ☐ 3 years of age or older

Q15. For PEDIATRIC PATIENTS, please select all that apply:

- ☐ The patient has short stature or slow growth velocity
- ☐ The patient has been evaluated for other causes of growth failure
- ☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic Hepatitis C ☐ Other

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

Q5. Please indicate the prescriber's specialty below:

☐ Gastroenterologist
☐ Hepatologist
☐ Infectious Disease Specialist
☐ Other

Q6. If the prescriber's specialty is OTHER, please specify:

Q7. Please provide the patient's genotype confirmed by HCV RNA level within the last 6 months (must submit documentation):

ENVISIONRx

# 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 subtype (must submit documentation):

Q9. Please provide the patient's HCV RNA (viral load) level (must submit documentation):

Q10. Is the patient post-transplant?

☐ Yes ☐ No

Q11. What is the patient's cirrhosis status?

Q12. What is the patient's prior treatment history?

Q13. What is the patient's planned duration of treatment?

Q14. 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?

☐ Yes ☐ No

Q15. For Vosevi: Has the patient previously tried and failed (or had a contraindication or intolerance to) Mavyret?

☐ Yes
☐ No
☐ 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:** |
|---|---|

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-24-hour-sleep-wake disorder (Non-24) ☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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

ENVISIONRx

# 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?

☐ Initial ☐ Continuing

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

Q3. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

Q4. Please indicate the diagnosis for which the requested medication is being prescribed:

☐ Attention deficit hyperactivity disorder (ADHD)
☐ Hypertension
☐ 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

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

Q3. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

Q4. Please indicate the diagnosis for which the requested medication is being prescribed:

☐ Tension or muscle contraction headache
☐ Acute Pain
☐ Osteoarthritis
☐ Gout
☐ Ankylosing Spondylitis
☐ Rheumatoid Arthritis
☐ Other

Q5. If the diagnosis is OTHER, please specify below:

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial ☐ Continuing

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

Q3. Please indicate the patient's diagnosis below:

☐ Ventricular arrhythmia ☐ Other

Q4. If the diagnosis is OTHER, please specify.

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

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.

# 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?

☐ Initial ☐ Continuing

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

Q3. Please indicate which medication is being requested:

- ☐ Amitriptyline
- ☐ Doxepin
- ☐ Clomipramine (Anafranil)
- ☐ Imipramine HCl (Tofranil)
- ☐ Imipramine Pamoate (Tofranil-PM)
- ☐ Trimipramine (Surmontil)
- ☐ None of the above
- ☐ Other

Q4. If medication is Other, please specify:

Q5. Please provide the patient's diagnosis below:

- ☐ Obsessive-Compulsive Disorder
- ☐ Depression
- ☐ Anxiety

ENVISIONRx

# 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:** |
|---|---|

☐ Enuresis
☐ Other

Q6. If the diagnosis is OTHER, please specify.

Q7. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):

Q3. Please indicate which medication is requested:

☐ Hydroxyzine
☐ Promethazine
☐ Trimethobenzamide
☐ Other

Q4. If medication is Other, Please specify:

Q5. Is the patient 65 years of age or older?

☐ Yes ☐ No

Q6. Please indicate the patient's diagnosis for the requested medication:

☐ Pruritus/Allergic conditions
☐ Sedation
☐ Anxiety/tension
☐ Nausea/Vomiting

ENVISIONRx

# 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:** |
|---|---|

- ☐ Motion sickness
- ☐ Adjunct to analgesia
- ☐ 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

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

Q3. Please indicate the patient's diagnosis below:

☐ Allergic/vasomotor rhinitis
☐ Allergic conjunctivitis
☐ Urticaria
☐ Hypersensitivity reaction
☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ 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

ENVISIONRx

# 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.**

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 below:

☐ Parkinson's disease
☐ Extrapyramidal disease - Medication-induced movement disorder
☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial ☐ Continuing

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:

☐ Schizophrenia ☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

# 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 | Date |

ENVISIONRx

# 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.**

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 diagnosis for which the requested medication is being prescribed:

☐ Seizure Disorder
☐ Anxiety
☐ Insomnia
☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

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.

ENVISIONRx

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Dementia (progressive, Alzheimer's, or senile onset) ☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Is the patient 65 years of age or older?

☐ Yes ☐ No

Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Antidementia: donepezil, galantamine, memantine ER, rivastigmine capsule, rivastigmine patch.

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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.**

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 diagnosis for which this medication is being prescribed:

☐ Abnormal vasomotor function (Moderate to Severe) - Menopause
☐ Atrophic vulva/vagina (Moderate to Severe) - Menopause
☐ Prevention of postmenopausal osteoporosis
☐ Decreased estrogen level, Secondary to hypogonadism, castration, or primary ovarian failure
☐ Breast cancer, Metastatic; for palliation only
☐ Prostate cancer, Advanced, Androgen-dependent; for palliation only
☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Localized options: Premarin Cream and Estradiol Cream. Osteoporosis: Alendronate and Risedronate.

ENVISIONRx

# 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:** |
|---|---|
| | |

Prescriber Signature

Date

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

- ☐ Acute Painful Musculoskeletal conditions
- ☐ Chronic Intermittent Painful Musculoskeletal conditions
- ☐ Fibromyalgia
- ☐ Restless Leg Syndrome
- ☐ Nocturnal Leg Cramps
- ☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

# 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

Date

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the diagnosis for which the requested medication is being prescribed: *

☐ Cachexia associated with AIDS
☐ Breast cancer, palliative treatment of advanced disease
☐ Endometrial carcinoma, palliative treatment of advanced disease
☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives for diagnosis of cachexia secondary to chronic illness are: dronabinol, oxandrolone.

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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.**

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 below:

☐ Heart valve replacement - Thromboembolic disorder; Prophylaxis
☐ Cerebrovascular accident; Prophylaxis
☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Platelet Inhibitors: Cilostazol, Clopidogrel.

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):

Q3. Please indicate the patient's diagnosis:

☐ Insomnia ☐ Other

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

Q5. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

# 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:** |
|---|---|
| Prescriber Signature | Date |

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Ankylosing Spondylitis
☐ Crohn's Disease (moderate to severe)
☐ Hidradenitis suppurativa (moderate to severe)
☐ Non-infectious Uveitis (including intermediate, posterior, and panuveitis)
☐ Plaque psoriasis (chronic)
☐ Polyarticular juvenile idiopathic arthritis (pJIA) (moderate to severe)
☐ Psoriatic arthritis
☐ Rheumatoid arthritis (moderate to severe)
☐ Ulcerative colitis (moderate to severe)
☐ Other

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?

☐ Yes ☐ No

Q5. If the patient's diagnosis is OTHER, please specify below:

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

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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:** |
|---|---|

☐ RA or pJIA - one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months

☐ PSORIATIC ARTHRITIS - methotrexate

☐ ANKYLOSING SPONDYLITIS - one or more non-steroidal anti-inflammatory drugs (NSAIDs)

☐ PLAQUE PSORIASIS - conventional therapy with phototherapy (such as UVA with a psoralen [PUVA] and/or retinoids [RePUVA]) for at least one continuous month

☐ 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

☐ CROHN'S DISEASE - two or more corticosteroids or non-biologic DMARDs

☐ ULCERATIVE COLITIS - two or more corticosteroids, 5-ASA (such as mesalamine, sulfasalazine, balsalazide), or non-biologic DMARDs (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, sulfasalazine)

☐ UVEITIS - one of the following: systemic or topical corticosteroids or ophthalmic antimuscarinics

☐ None of the above

Q7. Please indicate the patient's age below:

☐ Under 2 years
☐ 2-5 years
☐ 6-11 years
☐ 12-17 years old
☐ 18 years or older

Q8. Does the patient have any active serious infections (including tuberculosis [TB])?

☐ Yes ☐ No

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)?

☐ Yes ☐ 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:** |
|---|---|

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):

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

☐ Breast cancer, advanced or metastatic ☐ Other

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

Q5. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?

☐ Yes ☐ No

Q6. Please indicate how the requested medication will be used:

☐ In combination with an aromatase inhibitor in a postmenopausal women or a man, as initial endocrine-based therapy

☐ In combination with fulvestrant in a woman with disease progression following endocrine therapy

☐ None of the above

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

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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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q8. Is the medication prescribed by (or in consultation with) an oncologist? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute lymphoblastic leukemia, Philadelphia chromosome-positive (Ph+ALL)
☐ Chronic myeloid leukemia (CML) (chronic, accelerated, or blast phase)
☐ Other

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

Q5. Please select if any of the following apply to this patient (please select all that apply):

☐ No other tyrosine kinase inhibitor therapy is indicated for this patient
☐ The patient is T315I-positive
☐ None of the above

Q6. Please indicate the prescriber's specialty below:

☐ Hematologist ☐ Oncologist ☐ Other

Q7. If the prescriber's specialty is OTHER, please specify below:

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia (AML), relapsed/refractory ☐ 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?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication prescribed by (or in consultation with) a hematologist or oncologist?

☐ Yes ☐ No

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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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Inbrija-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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Parkinson's disease ☐ Other

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

Q5. Will the requested medication be used concurrently with carbidopa/levodopa?
☐ Yes ☐ No

Q6. Has the patient tried and failed (or has contraindication to) one generic formulary alternative?
☐ Yes ☐ No

Q7. Is the patient 18 years old or older?
☐ Yes ☐ No

Q8. Do any of the following apply to this patient (please select all that apply)?
☐ The patient is currently taking a nonselective monoamine oxidase inhibitor (MAOI) (such as phenelzine or

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# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Inbrija-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:** |
|---|---|

tranylcypromine)

- ☐ The patient has recently (within 2 weeks) taken a nonselective MAOI
- ☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic graft-versus-host-disease (cGVHD) (after failure of one or more lines of systemic therapy)
☐ Chronic lymphocytic leukemia (CLL) with or without 17p deletion
☐ Mantle cell lymphoma (MCL) (in patients who have received at least 1 prior therapy)
☐ Marginal zone lymphoma, relapsed/refractory (in patients who require systemic therapy and have received at least 1 prior anti-CD20-based therapy)
☐ Small lymphocytic lymphoma (SLL) with or without 17p deletion
☐ Waldenstrom macroglobulinemia
☐ Other

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

# 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

ENVISIONRx

# 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.**

Q1. Is the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Severe primary insulin-like growth factor-1 deficiency (IGF-1 deficiency; primary IGFD)
☐ Growth hormone (GH) gene deletion in a patient that has developed neutralizing antibodies to growth hormone
☐ Genetic mutation of GH receptor (i.e. Laron Syndrome)
☐ Other

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

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?

☐ Yes ☐ No

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?

☐ Yes ☐ No

ENVISIONRx

# 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?

☐ Yes ☐ No

Q8. Is there evidence of open epiphyses?

☐ Yes ☐ No

Q9. Does the patient have allergies to mecasermin or any component of the Increlex formulation?

☐ Yes ☐ No

Q10. Will the medication be used for growth promotion in patients with closed epiphyses?

☐ Yes ☐ No

Q11. Will Increlex be administered intravenously?

☐ Yes ☐ No

Q12. Does the patient have active or suspected neoplasia?

☐ Yes ☐ No

Q13. Please indicate the prescriber's specialty below:

☐ Pediatrics ☐ Endocrinologist ☐ Other

Q14. If the prescriber's specialty is other, please describe below:

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Dyspareunia (moderate to severe)
☐ Atrophic vaginitis
☐ Other

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

Q5. Is the patient's condition caused by menopause?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

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

☐ Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin
☐ Known or suspected estrogen-dependent neoplasia

ENVISIONRx

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (metastatic) ☐ 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?

☐ Yes ☐ No

Q6. Is the medication prescribed by (or in consultation with) an oncologist?

☐ Yes ☐ No

Q7. Is the patient 18 years old or older?

☐ Yes ☐ No

ENVISIONRx

# 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

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Chronic iron overload in nontransfusional-dependent thalassemia syndromes
☐ Chronic iron overload due to blood transfusions
☐ Other

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

Q5. Please indicate the patient's age:

☐ Under 2 years ☐ 2 years and older

Q6. What is the patient's serum creatinine level?

Q7. What is the patient's serum ferritin level?

Q8. Is the requested medication prescribed by a hematologist?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

Q3. Please indicate the diagnosis for which Itraconzole is being requested: *

☐ Systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis)
☐ Onychomycosis
☐ Candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole (ORAL SOLUTION ONLY)
☐ Other

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

Q5. For ONYCHOMYCHOSIS, has the diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)?

☐ Yes ☐ No

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:** |
|---|---|

ENVISIONRx

# 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.**

Q1. Is the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

Q3. Please indicate the diagnosis for which IVIG therapy is being requested:

☐ Acute and chronic immune Idiopathic Thrombocytopenic Purpura (ITP)
☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)
☐ Primary humoral immunodeficiency syndrome (congenital agammaglobulinemia, severe combined immunodeficiency syndromes [SCIDS], common variable immunodeficiency, X-linked immunodeficiency, Wiskott-Aldrich syndrome)
☐ Prevention of bacterial infection in patients with hypogammaglobulinemia and/or recurrent bacterial infections with B-cell chronic lymphocytic leukemia (CLL)
☐ Prevention of coronary artery aneurysms associated with Kawasaki syndrome
☐ Motor neuropathy with multiple conduction block
☐ Other

Q4. For CIDP: Has diagnosis been confirmed by a neurologist?

☐ Yes ☐ No

Q5. If the diagnosis is OTHER, please specify below:

ENVISIONRx

# 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:** |
|---|---|

Q6. Does the patient have IgA deficiency with antibody formation and a history of hypersensitivity?

☐ Yes ☐ No

Q7. Does the patient have a history of anaphylaxis or severe systemic reaction to human immune globulin?

☐ Yes ☐ 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?

☐ Yes ☐ 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?

☐ Yes ☐ No ☐ Not applicable

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Homozygous familial hypercholesterolemia ☐ Other

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

Q5. Has the patient had an inadequate response or intolerance to statins?

☐ Yes ☐ No

Q6. Does the patient have any of the following (please select all that apply)?

- ☐ Moderate to severe liver impairment
- ☐ Active liver disease including unexplained persistent abnormal liver function tests
- ☐ Pregnant
- ☐ Concomitant use with strong or moderate CYP3A4 inhibitors
- ☐ None of the above

# 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

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystic fibrosis ☐ Other

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

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?

☐ Yes ☐ No

Q6. For CONTINUING THERAPY, has the patient experienced improved or stable lung function while on Kalydeco therapy?

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Please indicate which medication this request is for:

☐ Kisqali ☐ Kisqali Femara

Q2. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q3. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Breast cancer (advanced or metastatic) ☐ Other

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Please select all that apply to this patient:

☐ The patient is a postmenopausal female
☐ The patient is a premenopausal or perimenopausal female
☐ The patient's disease is hormone receptor (HR)-positive
☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative
☐ The medication will be used in combination with an aromatase inhibitor for initial endocrine-based treatment
☐ The medication will be used in combination with fulvestrant as initial endocrine based therapy or following disease progression on endocrine therapy (does not apply to Kisqali-Femara Co-pack)

ENVISIONRx

# 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:** |
|---|---|

☐ None of the above

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hyperglycemia (in a patient with endogenous Cushing's syndrome who has failed surgery or who is ineligible for surgery)

☐ Other

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

Q5. Is the patient pregnant?

☐ Yes
☐ No
☐ Patient is not female

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ 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: *

☐ To reduce blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA) ☐ Other

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

Q5. What is the patient's age?

☐ 12 years or younger ☐ Greater than 12 years

Q6. What is the pretreatment blood phenylalanine (Phe) level?

☐ Greater than or equal to 10mg/dl
☐ Between 6mg/dl and 10mg/dl
☐ 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?

☐ Yes ☐ 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

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Homozygous familial hypercholesterolemia ☐ 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?
☐ Yes ☐ No

Q6. Does the patient have moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests?
☐ Yes ☐ No

Q7. For CONTINUING THERAPY, has the patient responded to therapy with a decrease in LDL levels?
☐ Yes ☐ No

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hepatocellular carcinoma (unresectable)
☐ Renal cell carcinoma (advanced)
☐ Thyroid cancer, differentiated (locally recurrent or metastatic, progressive)
☐ Other

Q4. For RENAL CELL CARCINOMA, will the requested medication be used in combination with everolimus (Afinitor)?

☐ Yes ☐ No

Q5. For RENAL CELL CARCINOMA, has the patient received at least one (1) prior anti-angiogenic therapy?

☐ Yes ☐ No

Q6. For THYROID CANCER, is the patient's disease refractory to radioactive iodine?

☐ Yes ☐ No

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

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH), WHO Group I ☐ 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.)?

☐ Yes ☐ No

Q6. Is the patient pregnant?

☐ Yes ☐ No

Q7. For FEMALE PATIENTS OF CHILD-BEARING POTENTIAL, please select all that apply:

☐ Pregnancy has been excluded prior to the start of therapy
☐ The patient has been educated about the potential hazards associated with Letairis use in pregnancy
☐ 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

ENVISIONRx

# 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.**

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 diagnosis for which Leukine is being requested:

☐ Acute myelogenous leukemia (AML), following induction chemotherapy
☐ Bone marrow transplant (allogeneic or autologous) failure or engraftment delay
☐ Myeloid reconstitution after allogeneic bone marrow transplantation
☐ Myeloid reconstitution after autologous bone marrow transplantation: Non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL), Hodgkin's lymphoma
☐ Peripheral stem cell transplantation: Mobilization and myeloid reconstitution following autologous peripheral stem cell transplantation
☐ Other

Q4. For AML only, is there excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood?

☐ Yes
☐ No
☐ N/A - patient does not have AML

Q5. If the diagnosis is OTHER, please specify below:

ENVISIONRx

# 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.**

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|---|---|

Q6. For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy, please check all that apply:

- ☐ Leukine is being used for the prevention of chemotherapy-induced febrile neutropenia and the patient has experienced febrile neutropenia with a prior chemotherapy cycle
- ☐ The patient is at high risk (greater than 20%) for developing febrile neutropenia
- ☐ The patient is at intermediate risk (10-20%) for developing febrile neutropenia.
- ☐ 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.
- ☐ None of the above

Q7. Is Leukine being requested for treatment of febrile neutropenia in a patient who has received prophylaxis with Leukine (or Neupogen)?

☐ Yes ☐ No

Q8. Will patient receive baseline and regular monitoring of complete blood counts and platelet counts?

☐ Yes ☐ No

Q9. Is patient at risk for infection-related complications?

☐ Yes ☐ No

Q10. Will Leukine be administered within 24 hours preceding or following chemotherapy or radiotherapy?

☐ Yes ☐ No

Q11. Is Leukine being used for prophylaxis to to increase the chemotherapy dose intensity or dose schedule above established regimens?

☐ Yes ☐ No

Q12. For treatment of febrile neutropenia: Did the patient receive Neulasta during the current chemotherapy cycle?

☐ Yes ☐ No

Q13. Does patient have a known hypersensitivity to yeast-derived products?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date below (MM/YY):

Q3. Does the patient have postherpetic neuralgia?

☐ Yes ☐ No

Q4. Does the patient have diabetic peripheral neuropathy?

☐ Yes ☐ No

Q5. If the diagnosis is NOT postherpetic neuralgia or diabetic peripheral neuropathy, please specify the patient's diagnosis below:

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)?

☐ Cymbalta
☐ Lyrica
☐ Other
☐ None of the above

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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:** |
|---|---|

| |
|---|
| 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

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

Q5. Is the patient anaplastic lymphoma kinase (ALK)-positive?

☐ Yes ☐ No

Q6. Has the patient experienced disease progression on any of the following (please select all that apply)?

☐ Alectinib (Alecensa)
☐ Ceritinib (Zykadia)
☐ Crizotinib (Xalkori) AND at least 1 other ALK inhibitor for metastatic disease
☐ None of the above

Q7. Will the patient be taking this medication in combination with a strong CYP3A inducer?

☐ Yes ☐ No

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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:** |
|---|---|

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the requested medication being prescribed by (or in consultation with) an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):

Q3. Please indicate which medication the request is for:

☐ Leuprolide
☐ Lupron Depot Injection 3.75 mg
☐ Lupron Depot Injection 7.5 mg
☐ Lupron Depot Injection 11.25
☐ Lupron Depot Injection 22.5 mg
☐ Lupron Depot Injection 30 mg
☐ Lupron Depot Injection 45 mg
☐ Other

Q4. If medication is Other, Please specify:

Q5. Please indicate the patient's diagnosis for the requested medication:

☐ Prostate cancer (advanced or metastatic)
☐ Endometriosis
☐ Anemia due to uterine Leiomyomata (Fibroids)

ENVISIONRx

# 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:** |
|---|---|

☐ Central precocious puberty (idiopathic or neurogenic) in children
☐ Other

Q6. For ANEMIA DUE TO UTERINE LEIOMYOMATA (FIBROIDS), please select all that apply:

☐ Patient is preoperative ☐ None of the above

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

Q8. For FEMALE PATIENTS, select all that apply:

☐ Patient is pregnant
☐ Patient is breastfeeding
☐ Patient has undiagnosed abnormal vaginal bleeding
☐ None of the above

Q9. Will the patient be utilizing non-hormonal contraceptives during and for 12 weeks after therapy?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate which medication this request is for:

☐ Lynparza capsules ☐ Lynparza tablets

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Breast cancer, metastatic
☐ Epithelial ovarian, fallopian tube, or primary peritoneal cancer (recurrent)
☐ Ovarian cancer, advanced
☐ Other

Q5. For METASTATIC BREAST CANCER, please select all that apply to this patient:

☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative
☐ The patient has deleterious or suspected deleterious germline BRCA mutation (gBRCAm)
☐ The patient has been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting
☐ None of the above

Q6. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, has the patient had a complete or partial response to platinum-based chemotherapy?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Q7. For ADVANCED OVARIAN CANCER, please select all that apply to this patient:

☐ The patient has deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) advanced ovarian cancer

☐ The patient has been treated with three (3) or more prior lines of chemotherapy

☐ None of the above

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

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Mayzent-12 Medicare

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

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Relapsing forms of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease) ☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by (or in consultation with) a neurologist?

☐ Yes ☐ No

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

☐ CYP2C9*3/*3 genotype

☐ In the last 6 months, has experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Mayzent-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:** |
|---|---|

failure requiring hospitalization, or Class III-IV heart failure

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

☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Melanoma (adjuvant treatment)
☐ Melanoma (unresectable or metastatic)
☐ Non-small cell lung cancer (metastatic) (with BRAF V600E mutation)
☐ Thyroid cancer, anaplastic (locally advanced or metastatic) (with BRAF V600E mutation)
☐ 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?

☐ Yes ☐ No

Q6. Is the requested medication being prescribed by an oncologist?

☐ Yes ☐ No

ENVISIONRx

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Melanoma (unresectable or metastatic malignant) ☐ 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?
☐ Yes ☐ No

Q6. Will Mektovi be used in combination with Braftovi (encorafenib)?
☐ Yes ☐ No

Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist?
☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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: | |
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| 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 provide the start date (MM/YY):

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

☐ Gaucher disease, type 1 (mild to moderate) ☐ Other

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

Q5. Is the patient a candidate for enzyme replacement therapy?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ 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

# 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?

☐ Initial therapy ☐ 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)?

☐ Yes ☐ No

Q4. Please indicate which medication this request is for:

☐ Aubagio
☐ Avonex
☐ Betaseron
☐ Gilenya
☐ Glatiramer
☐ Plegridy
☐ Tecfidera

Q5. For AUBAGIO, please select all that apply to this patient:

☐ Patient has severe hepatic impairment
☐ Patient is currently being treated with leflunomide
☐ Patient is pregnant

ENVISIONRx

# 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:** |
|---|---|

☐ Patient is a woman of child-bearing potential who is NOT using reliable contraception

☐ None of the above

Q6. For GILENYA, please select all that apply to this patient:

☐ Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure

☐ History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker

☐ Baseline QTc interval greater than or equal to 500 ms

☐ Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (such as quinidine, procainamide, amiodarone, or sotalol)

☐ None of the above

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?

☐ Yes ☐ No

Q8. For GLATIRAMER, is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Please indicate the patient's diagnosis for the requested medication:

☐ Multiple sclerosis (relapsing forms)

☐ First clinical episode and patient has MRI features consistent with multiple sclerosis

☐ Other

Q10. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hypocalcemia due to hypoparathyroidism ☐ Other

Q4. If diagnosis is OTHER, please specify:

Q5. Is the Prescriber certified in the NATPARA REMS program?

☐ Yes ☐ No

ENVISIONRx

# 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 |

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Breast cancer (early stage HER2-overexpressed) ☐ 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?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is Nerlynx prescribed by (or in consultation with) an oncologist?
☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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?
☐ 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:
☐ Multiple myeloma ☐ 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?
☐ Yes ☐ No

Q6. Has the patient received at least one (1) prior therapy?
☐ Yes ☐ No

Q7. Is the patient 18 years old or older?
☐ Yes ☐ No

Q8. Is the medication prescribed by or in consultation with a hematologist/oncologist?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Neurogenic orthostatic hypotension (NOH) ☐ Other

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

Q5. If the patient has a diagnosis of NOH, is the NOH due to any of the following (please select all that apply)?

☐ Primary autonomic failure (Parkinson's disease, multiple system atrophy, or pure autonomic failure)
☐ Dopamine beta-hydroxylase deficiency
☐ Non-diabetic autonomic neuropathy
☐ None of the above

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:

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

☐ Orthostatic dizziness

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Severe asthma (Add-on maintenance treatment)
☐ Eosinophilic granulomatosis with polyangiitis (EGPA)
☐ Other

Q4. For ASTHMA, does the patient have an eosinophilic phenotype?

☐ Yes ☐ No

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by a pulmonologist or immunologist?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Pseudobulbar affect (PBA) ☐ Other

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

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:** |
|---|---|

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Parkinson's disease - Psychotic disorder ☐ Other

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

Q5. Is the patient experiencing hallucinations and/or delusions?

☐ Yes ☐ No

ENVISIONRx

# 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 |

ENVISIONRx

# 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.**

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 diagnosis for which Octreotide is being requested:

☐ Acromegaly
☐ Metastatic carcinoid tumors
☐ Watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas)
☐ Other

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

# 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:** |
|---|---|
| Prescriber Signature | Date |

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH) (World Health Organization group 1) ☐ Other

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

Q5. Has diagnosis been confirmed by right heart catheterization?

☐ Yes ☐ No

Q6. For FEMALE PATIENTS, please select all that apply:

- ☐ The patient is enrolled in the OPSUMIT REMS program
- ☐ The patient is NOT pregnant
- ☐ The patient will use an IUD or two appropriate contraceptive methods
- ☐ N/A - The patient is not female or not of child-bearing potential

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. For CONTINUING THERAPY, is the patient tolerating and responding to the medication as evidenced by the following (please select all that apply)?

- ☐ Improved FEV1
- ☐ Weight gain
- ☐ Decreased exacerbations
- ☐ Other
- ☐ None of the above

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Cystic Fibrosis (CF) ☐ Other

Q5. If diagnosis is OTHER, please specify below:

Q6. Is the patient homozygous for the F508del mutation in the CFTR gene as confirmed by an FDA-approved CF test?

☐ Yes ☐ No

ENVISIONRx

# 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:** |
|---|---|

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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):

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

☐ Endometriosis (with moderate to severe pain) ☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Does the patient have any of the following (please select all that apply)?

☐ Pregnancy
☐ Known osteoporosis
☐ Severe hepatic impairment
☐ Current use of strong organic anion transporting polypeptide (OATP) 1B1 inhibitors
☐ None of the above

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Dyspareunia (moderate to severe)
☐ Atrophic vaginitis
☐ Moderate to severe vaginal dryness due to menopause
☐ Other

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

Q5. Is the patient's condition caused by menopause?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

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

☐ Acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT,

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# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Osphena-1 Medicare

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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

Date

# 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.**

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: *

☐ To promote weight gain (adjunct therapy) ☐ Other

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

Q5. Does the patient have any of the following exclusions? (Please select all that apply):

- ☐ Known or suspected carcinoma of the prostate or breast (in male patients)
- ☐ Carcinoma of the breast in a female patient with hypercalcemia
- ☐ Nephrosis (the nephrotic phase of nephritis)
- ☐ Hypercalcemia
- ☐ Pregnancy
- ☐ None of the above

# 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:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Neurotrophic keratitis ☐ 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?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

PCSK9 Inhibitors-14 Medicare

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

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

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| 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 which medication this request is for:

☐ Praluent ☐ Repatha

Q4. Please indicate the patient's diagnosis for the requested medication:

☐ Primary hypercholesterolemia Heterozygous Familial Hypercholesterolemia (HeFH)
☐ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH)
☐ Clinical Atherosclerotic Cardiovascular Disease (CVD)
☐ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in pts with established CVD
☐ Other

Q5. FOR HeFH: has the diagnosis been confirmed by either of the following?

☐ Genotyping
☐ Medically accepted diagnostic criteria
☐ None of the above

Q6. For HoFH, has the diagnosis been confirmed by any of the following? (please select all that apply):

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# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

PCSK9 Inhibitors-14 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the 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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|---|---|

- ☐ Genotyping
- ☐ History of untreated LDL-C greater than 500 mg/dL
- ☐ Xanthoma before 10 years of age
- ☐ Documentation of HeFH in both parents
- ☐ None of the above

Q7. FOR CARDIOVASCULAR DISEASE: has the patient experienced any of the following? (please select all that apply):

- ☐ Acute coronary syndrome
- ☐ History of myocardial infarction
- ☐ Stable or unstable angina
- ☐ Coronary or other arterial revascularization
- ☐ Stroke
- ☐ Transient ischemic attack (TIA)
- ☐ Peripheral arterial disease (PAD) presumed to be atherosclerotic region
- ☐ None of the above

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

Q9. Please provide the patient's baseline and current LDL-C cholesterol levels below:

Q10. Please indicate the patient's age:

- ☐ Less than 13 years of age
- ☐ 13-17 years of age
- ☐ 18 years of age or older

Q11. Please select all that apply to this patient:

- ☐ Patient's LDL-C level is greater than or equal to 70 mg/dL
- ☐ The requested medication will be used in combination with maximally tolerated high-intensity statin therapy
- ☐ Statins are not tolerated by the patient
- ☐ None of the above

Q12. If statins are contraindicated or not tolerated by the patient, please explain below:

Q13. Is the medication being prescribed by, or in consultation, with any of the following provider specialties?

- ☐ Cardiologist
- ☐ Endocrinologist
- ☐ Lipid specialist

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# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

PCSK9 Inhibitors-14 Medicare

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

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

☐ None of the above

Q14. FOR CONTINUING THERAPY: please select all that apply to this patient:

☐ The requested medication will continue to be used in combination with maximally tolerated statin

☐ Statin therapy is not tolerated by the patient

☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ 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: *

☐ Chronic Hepatitis B ☐ Chronic Hepatitis C ☐ 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?

☐ Treatment naive (i.e. no previous treatment for Hepatitis C) ☐ 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?

☐ Yes ☐ No

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

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# 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):

- ☐ Decompensated liver disease
- ☐ Autoimmune hepatitis
- ☐ Concomitant administration of didanosine with ribavirin in patients co-infected with HIV
- ☐ None of the above

Q10. Please select the prescriber's specialty:

- ☐ Infectious disease (ID)
- ☐ Gastroenterology
- ☐ Oncology
- ☐ Other

Q11. If the prescriber specialty is Other, please describe below:

Q12. Will the patient be monitored for evidence of depression?

☐ Yes ☐ No

Q13. Please indicate the patient's age below:

- ☐ 0 to 2 years
- ☐ 3 - 4 years old
- ☐ 5-17 years
- ☐ 18 years old or older

Prescriber Signature

Date

ENVISIONRx

# 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: | |
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| 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?

☐ Initial therapy ☐ Continuing therapy

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

Q3. Please indicate the patient's diagnosis below:

☐ Multiple myeloma, in combination with dexamethasone ☐ Other

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

Q5. Please select all that apply to this patient:

☐ Patient has received at least two (2) prior therapies including lenalidomide (Revlimid) and a proteasome inhibitor (bortezomib (Velcade))

☐ Disease has progressed within 60 days of completion of the last therapy

☐ Patient has been counseled about the use of reliable contraception before, during and 1 month after initiation of therapy

☐ 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)

☐ Patient is registered and certified to be compliant with Pomalyst REMS (Risk Evaluation and Mitigation Strategy) program

☐ None of the above

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Pomalyst-1 Medicare

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

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|---|---|

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

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Promacta-3 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 request for initial or continuing therapy?

☐ Initial therapy ☐ 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:

☐ Idiopathic thrombocytopenic purpura (ITP)
☐ Hepatitis C infection associated thrombocytopenia
☐ Severe aplastic anemia with insufficient response to immunosuppressive therapy or in combination with immunosuppressive therapy
☐ Other

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

Q5. Has the patient had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy?

☐ Yes ☐ No

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?

☐ Yes ☐ No

ENVISIONRx

# 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.**

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|---|---|

Q7. Will liver function be assessed pretreatment and regularly throughout therapy?

☐ Yes ☐ 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?

☐ Yes ☐ 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)

☐ Yes ☐ 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?

☐ Yes ☐ 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?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ 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:

☐ Diabetic neuropathic ulcer ☐ 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)?

☐ Yes ☐ No

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**

Regranex-1 Medicare

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

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

Prescriber Signature

Date

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Revlimid-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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY please indicate the start date (MM/YY):

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

- ☐ Follicular lymphoma
- ☐ Mantle cell lymphoma
- ☐ Marginal zone lymphoma
- ☐ Multiple Myeloma
- ☐ Transfusion-dependent anemia
- ☐ Other

Q4. For MANTLE CELL LYMPHOMA, has the patient's disease relapsed or progressed after two (2) prior therapies (one of which included bortezomib)?

☐ Yes ☐ No

Q5. For MULTIPLE MYELOMA, please indicate how the requested medication will be used in this patient:

- ☐ As maintenance therapy following autologous stem cell transplant
- ☐ In combination with dexamethasone
- ☐ None of the above

ENVISIONRx

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Revlimid-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:** |
|---|---|

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?

☐ Yes ☐ No

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

Q8. For FOLLICULAR LYMPHOMA or MARGINAL ZONE LYMPHOMA, please select all that apply to this patient:

☐ The patient's disease has been previously treated
☐ The requested medication will be used in combination with a rituximab product
☐ None of the above

Q9. Is the patient enrolled in the Revlimid REMS Program?

☐ Yes ☐ No

Q10. Is the patient pregnant?

☐ Yes ☐ No

Q11. Have male and female patients of child-bearing potential been instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use?

☐ Yes ☐ No

Q12. Will the patient be monitored for signs and symptoms of thromboembolism?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Epithelial ovarian, fallopian tube, or primary peritoneal cancer (deleterious germline and/or somatic BRCA mutation associated)

☐ Epithelial ovarian, fallopian tube, or primary peritoneal cancer (recurrent)

☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is Rubraca being prescribed by a hematologist or oncologist?

☐ Yes ☐ No

Q7. Please select all that apply to this patient:

☐ The patient is BRCA mutation positive as detected by an approved FDA laboratory test

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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:** |
|---|---|

- ☐ 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia (AML), newly diagnosed
☐ Mast cell leukemia (MCL)
☐ Systemic mastocytosis
☐ Other

Q4. For ACUTE MYELOID LEUKEMIA, please select which of the following (if any) apply to this patient:

☐ The patient is treatment naïve
☐ The patient is FLT3 mutation-positive
☐ Rydapt will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy
☐ None of the above

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Is the patient 18 years of age or older?

ENVISIONRx

# 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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist? | |
| ☐ Yes | ☐ No |
| Q8. Does the patient have angioedema? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ 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:

☐ Hypervolemic hyponatremia
☐ Euvolemic hyponatremia
☐ Other

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

Q5. Does the patient have anuria?

☐ Yes ☐ No

Q6. Does the patient require an URGENT increase in serum sodium?

☐ Yes ☐ No

Q7. Is the patient able to sense and respond to thirst?

☐ Yes ☐ No

ENVISIONRx

# 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)?

☐ Yes ☐ No

Q9. Will Samsca be initiated or re-initiated in a hospital where serum sodium can be monitored closely?

☐ Yes ☐ No

Prescriber Signature

Date

# 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.**

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:

☐ Pulmonary arterial hypertension (PAH) (WHO Group I) ☐ Other

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

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.)?

☐ Yes ☐ No

Q6. Is the patient currently on nitrate therapy?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acromegaly
☐ Unresectable, well- or moderately-differentiated, locally advanced or metastatic carcinoid gastroenteropancreatic neuroendocrine tumor
☐ Hyperthyroidism secondary to thyrotropinoma
☐ Carcinoid syndrome
☐ Other

Q4. If diagnosis is ACROMEGALY, please check all that apply:

☐ Patient has had an inadequate response to surgery and/or radiotherapy
☐ Surgery and/or radiotherapy is not an option for this patient
☐ None of the above

Q5. If diagnosis is OTHER, please specify.

Q6. Is the patient 18 years of age or older?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acromegaly, Second-line therapy ☐ 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?

☐ Yes ☐ No

Q6. Has the patient tried and failed a 3 month trial of Sandostatin or Somatuline?

☐ Yes ☐ No

Q7. Is the medication being prescribed by an endocrinologist?

☐ Yes ☐ No

Q8. Will Somavert be administered IV?

ENVISIONRx

# 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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q9. Will the patient also be using Sandostatin or Somatuline while on Somavert therapy? | |
| ☐ Yes | ☐ No |
| Q10. FOR CONTINUING THERAPY, has the patient experienced a reduction in IGF-1 level from baseline? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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.**

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: *

☐ Chronic myeloid leukemia (CML) in chronic phase, Philadelphia chromosome-positive (Ph+) [newly diagnosed]
☐ Chronic myeloid leukemia (CML) in chronic, accelerated, myeloid or lymphoid blast phase, Philadelphia chromosome-positive (Ph+)
☐ Acute lymphoblastic leukemia (ALL), Philadelphia chromosome-positive (Ph+)
☐ Newly diagnosed Ph+ Acute lymphoblastic leukemia (ALL) in combination with chemotherapy
☐ Other

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

Q5. Has the patient had resistance or intolerance to prior therapy?

☐ Yes ☐ No

Q6. If yes, did the prior therapy include imatinib (Gleevec)?

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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.**

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:

☐ Colorectal cancer (metastatic)
☐ Gastrointestinal stromal tumors (GIST) (locally advanced, unresectable or metastatic)
☐ Hepatocellular carcinoma (previously treated with sorafenib [Nexavar])
☐ Other

Q4. For COLORECTAL CANCER, is the patient's disease KRAS mutation negative?

☐ Yes ☐ No

Q5. For COLORECTAL CANCER, please indicate which of the following the patient has previously tried (please select all that apply):

☐ Fluoropyrimidine-, oxaliplatin, and irinotecan-based chemotherapy
☐ Bevacizumab (Avastin)
☐ Panitumumab (Vectibix)
☐ Cetuximab (Erbitux)
☐ Other

ENVISIONRx

# 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):

- ☐ Imatinib mesylate (Gleevec)
- ☐ Sunitinib malate (Sutent)
- ☐ 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?

☐ Yes ☐ No

Q11. Is the requested medication being prescribed by an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease
☐ Renal cell carcinoma, advanced/metastatic
☐ Gastrointestinal stromal tumor
☐ Adjuvant treatment in renal cell carcinoma for patients at high risk of recurrence following nephrectomy
☐ Other

Q4. If the diagnosis is OTHER, please specify.

Q5. For GASTROINTESTINAL STROMAL TUMORS, has the patient had disease progression on or intolerance to Gleevec (imatinib)?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis below:

☐ Malignant Melanoma with microscopic or gross nodal involvement ☐ Other

Q4. If the diagnosis is OTHER, please specify:

Q5. Does the patient have any of the following (please select all that apply)?

☐ Autoimmune hepatitis
☐ Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])
☐ None of the above

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?

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Cystic fibrosis ☐ Other

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

Q5. Please select if any of the following apply to this patient:

☐ The patient is homozygous for the F508del mutation

☐ 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

☐ None of the above

Q6. Is the patient 12 years of age or older?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For INITIAL THERAPY, does the patient have inadequate glycemic control (HbA1c greater than 7% but less than 9%)?

☐ Yes ☐ 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?

☐ Yes ☐ No

Q5. Please indicate the patient's diagnosis for the requested medication:

☐ Diabetes mellitus (type 1 or type 2), adjunctive treatment ☐ Other

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

Q7. Is the patient currently receiving optimal mealtime insulin therapy?

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Melanoma (unresectable or metastatic) in a patient with BRAF V600E mutation (single agent therapy)
☐ Melanoma (unresectable or metastatic) in patients with BRAF V600E or V600K mutation (in combination with trametinib [Mekinist])
☐ Non-small cell lung cancer, Metastatic with BRAF V600E mutation, in combination with trametinib
☐ Anaplastic thyroid carcinoma, Locally advanced or metastatic, with BRAF V600E mutation, in combination with trametinib
☐ Other

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

Q5. Does the patient have a positive BRAF V600E or V600K mutation as detected by an FDA-approved test?

☐ Yes ☐ No

Q6. Does the patient have wild-type BRAF melanoma?

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

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

Q5. Was the patient's diagnosis confirmed by an FDA-approved test?

☐ Yes ☐ No

Q6. Please select if any of the following apply to this patient:

☐ The disease is metastatic EGFR mutation-positive
☐ There is confirmed presence of T790M EGFR tumor mutation
☐ The patient's disease has progressed on or after EGFR tyrosine kinase inhibitor based therapy
☐ None of the above

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Hereditary angioedema (prophylaxis) ☐ Other

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

Q5. Is the patient 12 years of age or older?
☐ Yes ☐ No

ENVISIONRx

# 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 |

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer (locally advanced or metastatic) ☐ 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)?

☐ Yes ☐ No

Q6. Is the patient's disease human epidermal growth factor receptor 2 (HER2)-negative?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase (newly diagnosed)
☐ Chronic phase (CP) and accelerated phase (AP) Ph+ CML
☐ Other

Q4. Is the patient resistant to or intolerant to prior therapy ?

☐ Yes ☐ No

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Is the requested medication being prescribed by an oncologist?

☐ Yes ☐ No

ENVISIONRx

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):

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

☐ Polyneuropathy of hereditary transthyretin-mediated amyloidosis ☐ Other

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

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the patient enrolled in the Tegsedi REMS program?

☐ Yes ☐ No

Q7. Do any of the following apply to the patient (please check all that apply)?

☐ Platelet count is below 100 x 10(9)/L
☐ Documented history of acute glomerulonephritis caused by inotersen
☐ 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):

Q3. Please indicate the patient's diagnosis below:

☐ Hypogonadism
☐ Deficiency or absence of endogenous testosterone
☐ Other

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

Q5. Do any of the following apply to this patient (please select all that apply)?

☐ Patient is female
☐ Patient has prostate cancer
☐ Patient has breast cancer
☐ None of the above

Q6. Please indicate the patient's testosterone level PRIOR to start of therapy:

☐ Total testosterone GREATER than 300 ng/dL, free or bioavailable testosterone GREATER than 5 ng/dL
☐ Total testosterone LESS than 300 ng/dL, free or bioavailable testosterone LESS than 5 ng/dL

# 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:** |
|---|---|

- ☐ Absence of endogenous testosterone
- ☐ None of the above

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ 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: *

☐ Chorea associated with Huntington disease ☐ 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)?

- ☐ Untreated or inadequately treated depression
- ☐ Actively suicidal
- ☐ History of hepatic disease
- ☐ Concurrent use of MAO inhibitors
- ☐ Concurrent use of reserpine (or it has been less than 20 days since reserpine was discontinued)
- ☐ None of the above

ENVISIONRx

# 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

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Multiple myeloma, newly diagnosed
☐ Acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum
☐ Severe erythema nodosum leprosum with cutaneous manifestations
☐ 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?

☐ Yes ☐ No

Q6. If the diagnosis is multiple myeloma, will the patient receive concurrent dexamethasone?

☐ Yes ☐ 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?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes
☐ No
☐ The patient does not have moderate to severe neuritis

Q8. Will the patient be monitored for signs and symptoms of venous thromboembolism?

☐ Yes ☐ No

Q9. Is the patient pregnant?

☐ Yes ☐ No ☐ Not applicable

Q10. Have male and female patients of child-bearing potential been instructed on the importance of proper utilization of appropriate contraceptive methods?

☐ Yes ☐ No

Q11. Is the patient 12 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Acute myeloid leukemia (AML), relapsed or refractory
☐ Acute myeloid leukemia (AML) in newly-diagnosed patients
☐ Other

Q4. For newly-diagnosed AML patients, please select all that apply to this patient:

☐ The patient is 75 years of age or older
☐ The patient has comorbidities that preclude use of intensive induction chemotherapy
☐ None of the above

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation?

☐ Yes ☐ No

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

ENVISIONRx

# 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:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q8. Is the patient 18 years of age or older? | |
| ☐ Yes | ☐ No |

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH) ☐ Other

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

Q5. Has the diagnosis of PAH been confirmed by either of the following?

☐ Right heart catheterization
☐ Doppler echocardiogram (if patient is unable to undergo a right heart catheterization)
☐ None of the above

Q6. Does the patient have World Health Organization (WHO) Group 1 and New York Heart Association (NYHA) Functional Class II-IV symptoms?

☐ Yes ☐ No

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?

ENVISIONRx

# 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:** |
|---|---|

☐ Yes
☐ No
☐ 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)?

☐ Yes ☐ No

Q9. Will the patient be receiving concomitant cyclosporine A or glyburide therapy?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Osteoporosis ☐ 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?
☐ Yes ☐ No

Q6. Is the patient at least 18 years of age or older?
☐ Yes ☐ No

Q7. Has the patient experienced a prior fragility fracture?
☐ Yes ☐ No

Q8. Does the patient have any of the following risk factors for fracture (please select all that apply)?
☐ Advanced age ☐ Rheumatoid arthritis

ENVISIONRx

# 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:** |
|---|---|

- ☐ Parental history of fracture
- ☐ Low body mass index (BMI)
- ☐ Current smoker
- ☐ Chronic alcohol use
- ☐ Chronic steroid use
- ☐ Other secondary cause of osteoporosis
- ☐ 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?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| 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. 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:
☐ Pulmonary arterial hypertension (PAH) (WHO Group I) ☐ Other

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

Q5. Has the patient's diagnosis been confirmed by right heart catheterization?
☐ Yes ☐ No

Q6. Has the patient tried and had an insufficient response to at least one other PAH agent (e.g. sildenafil)?
☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

# 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

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please indicate the start date: (MM/YY):

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

☐ Acute myeloid leukemia (AML), newly diagnosed
☐ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
☐ Other

Q4. For AML, please select all that apply to this patient:

☐ The patient is 75 years of age or older
☐ The patient has comorbidities that preclude use of intensive induction chemotherapy
☐ Venclexta will be used in combination with azacitadine, decitabine, or low-dose cytarabine
☐ None of the above

Q5. If the patient's diagnosis is OTHER, please specify below:

Prescriber Signature

Date

ENVISIONRx

# 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:** |
|---|---|

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Breast cancer (advanced or metastatic) ☐ Other

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

Q5. For BREAST CANCER, please select all that apply to this patient's disease:

☐ The patient's disease is hormone receptor (HR)-positive
☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative
☐ None of the above

Q6. For BREAST CANCER, please select all that apply to this patient's treatment:

☐ Verzenio will be used as monotherapy
☐ Verzenio will be used in combination with fulvestrant (Faslodex)
☐ Verzenio will be used as initial endocrine-based treatment in combination with an aromatase inhibitor
☐ The patient's disease has progressed following endocrine therapy
☐ The patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali

ENVISIONRx

# 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:** |
|---|---|

☐ None of the above

Q7. Is the medication being prescribed by (or in consultation with) an oncologist?

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Solid tumor ☐ Other

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

Q5. Is the patient's tumor neurotrophic receptor tyrosine kinase (NTRK) gene fusion positive without a known acquired resistance mutation?
☐ Yes ☐ No

Q6. Please select all that apply to this patient:
☐ The patient's disease is metastatic, or surgical resection is likely to result in severe morbidity
☐ There is no satisfactory alternative treatment (or the patient has progressed following treatment)
☐ None of the above

Q7. Is the requested medication being prescribed by (or in consultation with) an oncologist?
☐ Yes ☐ No

# 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

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

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

Q5. 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?
☐ Yes ☐ No

Q6. Is the medication being prescribed by (or in consultation with) an oncologist?
☐ Yes ☐ No

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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial Therapy ☐ Continuing Therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the diagnosis for which the requested medication is being prescribed:

☐ Non-small cell lung cancer, Metastatic, ALK-positive
☐ Non-small cell lung cancer, Metastatic, ROS1-positive
☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Is the prescribing physician an oncologist?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Rheumatoid arthritis (moderately to severely active)
☐ Psoriatic Arthritis
☐ Ulcerative Colitis
☐ Other

Q4. FOR Ulcerative Colitis: Is the patient corticosteroid dependent (ie, an inability to successfully taper corticosteroids without a return of the symptoms of UC)?

☐ Yes ☐ No

Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Has the patient had failure, contraindication, or intolerance to any of the following? (please select all that apply):

☐ Methotrexate
☐ Enbrel (etanercept)
☐ Humira (adalimumab)

ENVISIONRx

# 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:** |
|---|---|

- ☐ Oral aminosalicylate
- ☐ Oral corticosteroid
- ☐ Azathioprine
- ☐ 6-mercaptopurine
- ☐ 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)

☐ Yes ☐ No

Q9. Will the patient be receiving any of the following while taking Xeljanz?

- ☐ A biologic DMARD (such as Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab))
- ☐ A potent immunosuppressant (such as azathioprine or cyclosporine)
- ☐ None of the above

Q10. Is the requested medication prescribed by (or in consultation with) a rheumatologist or gastroenterologist?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

# 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.**

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:

☐ Bone metastases from solid tumors
☐ Giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity
☐ Hypercalcemia of malignancy refractory to bisphosphonate therapy
☐ Prevention of skeletal related events in patients with multiple myeloma
☐ Other

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

Q5. Does the patient have uncorrected hypocalcemia?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. What is the patient's diagnosis for the requested medication? *

☐ Chronic idiopathic urticaria
☐ Moderate to severe persistent allergic asthma
☐ Other

Q4. FOR URTICARIA, does the patient remain symptomatic despite H1 antihistamine treatment?

☐ Yes ☐ No

Q5. FOR CONTINUING THERAPY: Has a demonstrated improvement in asthma control been noted?

☐ Yes ☐ No

Q6. FOR ASTHMA, please select all that apply to this patient:

☐ 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

☐ Pretreatment serum IgE levels are greater than 30 and less than 1300 IU/mL

☐ 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

ENVISIONRx

# 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:** |
|---|---|

has a contraindication to ICS or LABA

☐ None of the above

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

Q8. Please indicate the patient's age below:

☐ Under 6 years ☐ 6 years or older

Q9. Please indicate the prescriber's specialty below:

☐ Allergist
☐ Immunologist
☐ Pulmonologist
☐ Dermatologist
☐ Other

Q10. If the prescriber's specialty is OTHER, please specify:

Prescriber Signature

Date

ENVISIONRx

# 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?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Acute myeloid leukemia, relapsed or refractory ☐ Other

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

Q5. Are FLT3 mutations present as detected by an FDA-approved test?
☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q7. Is the medication being prescribed by (or in consultation with) an oncologist or hematologist?
☐ Yes ☐ 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 |

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Prostate Cancer (metastatic, castration-resistant)
☐ Prostate Cancer (non-metastatic, castration-resistant)
☐ Other

Q4. FOR Metastatic prostate cancer: Has the patient tried and failed Zytiga?

☐ Yes ☐ 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:

☐ Oncologist ☐ Urologist ☐ None of the above

ENVISIONRx

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Hereditary orotic aciduria ☐ Other

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

Prescriber Signature

Date

# 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:** |
|---|---|

ENVISIONRx

# 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.**

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: *

☐ Excessive daytime sleepiness
☐ Cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy
☐ Other

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

Q5. Is that patient taking or receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines, or ethanol?

☐ Yes ☐ No

Q6. For CONTINUING THERAPY, has the patient experienced a decrease in daytime sleepiness and/or cataplexy?

☐ Yes ☐ No

# 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

ENVISIONRx

# 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.**

Q1. Is this request for initial or continuing therapy?
☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication below:
☐ Prostate Cancer (metastatic, castration-resistant) ☐ Other

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

Q5. Will the requested medication be used in combination with methylprednisolone?
☐ Yes ☐ No

Q6. Has the patient tried and failed (or has an intolerance or contraindication to) Zytiga (abiraterone)?
☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?
☐ Yes ☐ No

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

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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:** |
|---|---|

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

# 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?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Ovarian cancer (recurrent, epithelial)
☐ Fallopian tube cancer (recurrent)
☐ Primary peritoneal cancer (recurrent)
☐ 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?

☐ Yes ☐ No

Q6. Is Zejula being prescribed by (or in consultation with) an oncologist or gynecologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

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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:** |
|---|---|

Prescriber Signature

Date

# 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.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. What is the patient's diagnosis for the requested medication: *

☐ Anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) ☐ Other

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

Prescriber Signature

Date

# 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:** |
|---|---|

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Zytiga-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?

☐ Initial therapy ☐ 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:

☐ Metastatic prostate cancer (castration-resistant or high-risk castration-sensitive) ☐ Other

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

Q5. Will Zytiga be used combination with prednisone?

☐ Yes ☐ No

# COVERAGE DETERMINATION REQUEST FORM

**EOC ID:**
Zytiga-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