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 osteopetrosis (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

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Patient Name:	**Prescriber Name:**

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adagen-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: *
☐ Adenosine deaminase (ADA) deficiency in patient with severe combined immunodeficiency disease (SCID)
☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Is the medication to be used for direct replacement for deficient enzyme (no benefit achieved in patients with immunodeficiency due to other causes)?
☐ Yes ☐ No

Q6. Does the patient have severe thrombocytopenia?
☐ Yes ☐ No

Q7. Is the medication for use in preparation for or in support of bone marrow transplantation?
☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adagen-3 Medicare

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

Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adcirca-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) (World Health Organization group 1)
☐ Other

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

Q5. For PAH, is the patient symptomatic?
☐ Yes ☐ No

Q6. Was the diagnosis of PAH confirmed by right heart catheterization (or Doppler echocardiogram if patient is unable to undergo a right heart catheterization)?
☐ Yes ☐ No

Q7. Has the patient tried and had an insufficient response to therapy with at least one other PAH agent (such as sildenafil)?
☐ Yes ☐ No

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

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COVERAGE DETERMINATION REQUEST FORM

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Adcirca-3 Medicare

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q9. Will the patient concurrently be using organic nitrates or guanylate cyclase stimulators (on either a regular or intermittent basis)?

☐ Yes ☐ No

Q10. For CONTINUING THERAPY, is there documentation that the patient has had a positive clinical response to therapy?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adempas-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 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 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?
☐ Yes

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

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Adempas-3 Medicare

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Patient Name:	**Prescriber Name:**

☐ 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
☐ 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

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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
ADHD-2 Medicare

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

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Patient Name:	**Prescriber Name:**

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:

Aldurazyme-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:

- ☐ Hurler or Hurler-Scheie form of mucopolysaccharidosis I (MPS I)
- ☐ Scheie form of MPS I in a patient with moderate-to-severe symptoms
- ☐ Other

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

Q5. Please indicate which of the following diagnostic methods have been utilized to confirm diagnosis of Mucopolysaccharidosis:

- ☐ Measurement of alpha-L-iduronidase activity
- ☐ DNA Testing
- ☐ None of the above

Q6. For Scheie form of MPS I, does the patient have at least 2 moderate to severe symptoms?

☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Aldurazyme-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. FOR CONTINUING THERAPY, has the patient demonstrated improvement in lung function after receiving at least 26 weeks of therapy with Aldurazyme?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Aliqopa-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:
☐ Follicular lymphoma, relapsed ☐ Other

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

Q5. Is the medication prescribed by or in consultation with an oncologist?
☐ Yes ☐ No

Q6. Has the patient received at least two prior systemic therapies?
☐ Yes ☐ No

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Aliqopa-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:

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 the 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

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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-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:
☐ 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?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alunbrig-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:
Ampyra-2 Medicare

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or 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. What is 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 walking impairment, but with the ability to walk 25 feet (with or without assistance)?
☐ 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)?
☐ History of seizure
☐ Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute)

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ampyra-2 Medicare

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

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Patient Name:	**Prescriber Name:**

☐ None of the above

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Anabolic Steroids-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):	

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☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?
☐ 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 (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:
Anabolic Steroids-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:
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. 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

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

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:
- ☐ The patient experiences excessive sleepiness frequently (5 times or more per month)

ENVISIONRx

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 while working
☐ None of the above

Q8. Is the patient 17 years of age or older?
☐ Yes ☐ No

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 start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Cryopyrin-associated periodic syndrome (CAPS)
☐ Other

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

Q5. Is the patient 12 years of age or older?
☐ Yes ☐ No

Q6. 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

Q7. FOR CONTINUING THERAPY, has the patient's condition improved or stabilized?
☐ Yes ☐ No

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:
Atomoxetine-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:
☐ Attention deficit hyperactivity disorder (ADHD)
☐ Other

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

Q5. Will the patient be monitored for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, and liver injury?
☐ Yes ☐ No

Q6. Is the patient using an MAO-Inhibitor currently or has the patient used an MAO-I within the last 14 days?
☐ Yes ☐ No

Q7. Is the patient 6 years of age or older?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Atomoxetine-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
☐ 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 prescribed by or in consultation with a psychiatrist or neurologist?

☐ Yes ☐ No

Q9. Does the patient have any of these exclusions?

☐ Any degree of hepatic impairment or hepatic disease
☐ Active suicidal ideation or who have untreated or inadequately treated depression
☐ None of the above

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)
☐ Newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML)
☐ Other

Q4. FOR Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML): 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 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:
Botox-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:

- ☐ Axillary hyperhidrosis
- ☐ Cervical dystonia
- ☐ Chronic migraine
- ☐ Glabellar lines
- ☐ Lateral canthal lines
- ☐ Lower or upper limb spasticity
- ☐ Overactive bladder (OAB)
- ☐ Strabismus and blepharospasm associated with dystonia
- ☐ Urinary incontinence due to detrusor overactivity
- ☐ Other

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

Q5. Will the patient be monitored for life-threatening symptoms of spread of toxin effect from the injection site (e.g., breathing, swallowing difficulties)?

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Botox-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

Q6. Does the patient have hypersensitivity to any botulinum toxin preparation or any component of the formulation?

☐ Yes ☐ No

Q7. Does the patient have an infection at the proposed injection site(s)?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Briviact-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:

☐ Partial-onset seizure with epilepsy (adjunct therapy) ☐ Other

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

Q5. Has the patient tried and failed levetiracetam?

☐ Yes ☐ No

Q6. If the patient has NOT tried levetiracetam, is there a reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Briviact-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:

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?
☐ Yes ☐ No

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:**

Q8. Is the patient 7 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Cerezyme-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. For CONTINUING THERAPY in patients who have received at least 24 months of Cerezyme therapy, please select all that apply:

- ☐ Patient has had a decrease in liver and spleen volume
- ☐ Patient has had an increase in platelet count
- ☐ Patient has had an increase in Hemoglobin (Hgb) concentration
- ☐ None of the above

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

- ☐ Gaucher disease (Type 1)
- ☐ Other

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

Q6. Has the diagnosis been confirmed by any of the following (please select all that apply)?

- ☐ Bone marrow histology
- ☐ DNA testing
- ☐ B-glucocerebrosidase enzyme assay (enzyme activity less than 30 percent)

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Cerezyme-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:**

☐ None of the above

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

- ☐ Anemia
- ☐ Thrombocytopenia
- ☐ Bone disease
- ☐ Hepatomegaly
- ☐ Splenomegaly
- ☐ None of the above

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cimzia-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 the start date (MM/YY):

Q3. For CONTINUING THERAPY, has the patient's condition improved or stabilized while on therapy?
☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis for the requested medication:
☐ Ankylosing spondylitis (AS)
☐ Crohn's disease (moderately to severely active)
☐ Psoriatic arthritis (PsA)
☐ Rheumatoid arthritis (RA) (moderately to severely active)
☐ Other

Q5. For CROHN'S DISEASE, has the patient tried and failed (or has a contraindication or intolerance to) any of the following (please select all that apply)?
☐ At least one oral corticosteroid
☐ Humira
☐ None of the above

Q6. For RHEUMATOID ARTHRITIS, please select all that apply to this patient:
☐ The patient has had an inadequate response to either Enbrel or Humira

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cimzia-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 inadequate response to methotrexate (MTX)
☐ The patient has had an inadequate response to another non-biologic DMARD (such as leflunomide, hydroxychloroquine, or sulfasalazine) if MTX is contraindicated or the patient is intolerant
☐ The patient has had an intolerance or contraindication to at least 2 non-biologic DMARDs
☐ None of the above

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

Q8. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q9. Will the patient be using Cimzia in combination with other biologics?
☐ Yes ☐ No

Q10. Does the patient have any active infections (including tuberculosis [TB])?
☐ Yes ☐ No

Q11. Has the patient been screened for latent TB infection (LTBI) and if positive, the patient has completed treatment or is currently receiving treatment?
☐ Yes ☐ No

Q12. Has the patient been assessed for Hepatitis B virus (HBV) risk and HVB infection has been ruled out (or treatment has been initiated for positive infection)?
☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-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:
☐ Stable, symptomatic (NYHA Class II or III) chronic heart failure
☐ 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

Q8. Is the patient 18 years of age or older?
☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-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:**

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

- ☐ Decompensated acute heart failure
- ☐ Hypotension (i.e. blood pressure less than 90/50 mmHg)
- ☐ Sick sinus syndrome, sinoatrial block, or 3rd degree AV block (unless a functioning demand pacemaker is present)
- ☐ Bradycardia (i.e. resting heart rate is less than 60 beats per minute prior to treatment)
- ☐ None of the above

Prescriber Signature

Date

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

Prescriber Signature

Date

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:**

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

Q7. FOR N/V: Is the patient currently receiving a chemotherapy or radiation regimen?

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:**

☐ 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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Elaprase-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:
☐ Hunter syndrome (mucopolysaccharidosis type II [MPS II])
☐ Other

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

Q5. Has the patient's diagnosis been confirmed by any of the following (please select all that apply)?
☐ DNA testing
☐ Enzymatic analysis (deficiency of iduronate 2-sulfatase enzyme activity)
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Elaprase-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:
Empliciti-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 myeloma (relapsed or refractory)
☐ 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 prior treatment with 1 to 3 previous therapies?
☐ Yes ☐ No

Q7. Is the requested medication prescribed by an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Empliciti-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:
Enbrel-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 with Enbrel therapy?
☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis for the requested medication:
☐ Ankylosing spondylitis
☐ Crohn's Disease
☐ Plaque psoriasis
☐ Polyarticular juvenile idiopathic arthritis
☐ Psoriatic arthritis
☐ Rheumatoid arthritis
☐ Other

Q5. For CROHN'S DISEASE, please select all that apply to this patient:
☐ Patient has tried and failed (or had a contraindication or intolerance to) at least a 60-day trial of 2 conventional therapies (such as sulfasalazine, mesalamine, azathioprine, corticosteroids)
☐ Patient has tried and failed (or has a contraindication or intolerance to) either Remicade or Cimzia
☐ None of the above

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-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. For PLAQUE PSORIASIS, is the patient 18 years of age or older?

☐ Yes ☐ No

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

☐ Greater than 5% body surface area (BSA) is affected
☐ Crucial body areas (such as the feet, hands, face, or genitals) are affected
☐ Patient has tried and failed (or has a contraindication or intolerance to) at least a 60-day trial of 2 conventional therapies (such as phototherapy, calcipotriene, MTX, acitretin)
☐ None of the above

Q8. For POLYARTICULAR JIA, please select all that apply to this patient:

☐ Patient has had an inadequate response to at least one nonbiologic DMARD
☐ Patient has had an intolerance/contraindication to at least 2 nonbiologic DMARDs
☐ None of the above

Q9. For PSORIATIC ARTHRITIS, please select all that apply to this patient:

☐ Patient has predominantly peripheral symptoms
☐ Patient has tried and failed (or has a contraindication or intolerance to) at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic disease modifying anti-rheumatic drug (DMARD)
☐ None of the above

Q10. For RHEUMATOID ARTHRITIS, please select all that apply to this patient:

☐ The patient has had inadequate response to methotrexate (MTX)
☐ The patient has had an inadequate response to another nonbiologic DMARD (such as leflunomide, hydroxychloroquine, sulfasalazine) AND MTX is contraindicated or patient is intolerant
☐ The patient has had an intolerance or contraindication to at least 2 nonbiologic DMARDs
☐ The patient has severely active RA and Humira is being used first-line with MTX
☐ None of the above

Q11. If the diagnosis is OTHER, please specify below:

Q12. Has the patient been screened for latent tuberculosis (TB) infection and assessed for Hepatitis B (HBV) risk?

☐ Yes ☐ No

Q13. Has HBV infection been ruled out or treatment initiated for positive infection?

☐ Yes ☐ No

Q14. For POSTIVE LATENT TB INFECTION (LTBI), has the patient completed treatment or is currently receiving treatment for LTBI?

☐ Yes
☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Enbrel-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:**

☐ N/A - Patient did NOT test positive for LTBI

Q15. Does the patient have any of the following (please select all that apply)?

- ☐ Concomitant use with another biologic medication
- ☐ Active infection (including TB)
- ☐ None of the above

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. 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:

☐ Heart failure ☐ Other

Q4. If diagnosis is OTHER, please specify.

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. Please select if any of the following apply to this patient (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:
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. 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:
☐ 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:

Erwinaze-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 diagnosis for which Erwinaze is being prescribed:

☐ Acute lymphoid leukemia, in combination with other chemotherapeutic agents in patients with hypersensitivity to E coli-derived asparaginase

☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Has the patient developed hypersensitivity to Escherichia coli–derived asparaginase?

☐ Yes ☐ No

Q6. Please indicate the prescriber's specialty below:

☐ Hematology ☐ Oncology ☐ Other

Q7. If the prescriber specialty is Other, please describe below:

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Erwinaze-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:
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. Is the patient's pre-treatment hemoglobin level less than or equal to 10 g/dL?
☐ Yes ☐ No

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

Q4. For CONTINUING THERAPY after 12 weeks, has the hemoglobin increased at least 1 g/dL in response to epoetin alfa therapy?
☐ Yes ☐ No

Q5. 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

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

Q7. Does the patient have uncontrolled hypertension?

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:**

☐ Yes ☐ No

Q8. 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

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 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:
Exjade-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:
☐ Chronic iron overload due to blood transfusions (transfusional hemosiderosis)
☐ Non transfusion-dependent thalassemia syndromes
☐ Other

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

Q5. Please indicate the patient's age below:
☐ Under 2 years ☐ 2-9 years ☐ 10 years or older

Q6. Is the prescriber a Hematologist?
☐ Yes ☐ No

Q7. Will the patient have baseline and monthly monitoring of serum ferritin, serum creatinine, creatinine clearance, serum transaminases, and bilirubin?
☐ Yes ☐ No

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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Exjade-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:**

- ☐ Creatinine clearance less than 40 mL/min or evidence of overt proteinuria
- ☐ Platelet count less than 50 x 10(9)/L
- ☐ Advanced malignancy
- ☐ High-risk myelodysplastic syndrome (MDS) with poor performance status
- ☐ None of the above

Q9. Is the patient currently using any deferoxamine or iron-containing products?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Fabrazyme-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:

☐ Fabry disease ☐ Other

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

Q5. Has the diagnosis of Fabry disease been confirmed by an enzyme assay showing deficiency of alpha-galactosidase enzyme activity or DNA testing?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Fabrazyme-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. 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 ☐ Other

Q4. If 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 medication prescribed by or in consultation with an oncologist/hematologist?
☐ Yes ☐ No

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:**

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl-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:
☐ Management of breakthrough cancer pain in an opioid-tolerant patient
☐ Other

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

Q5. Please indicate the patient's age below:
☐ Under 16 years ☐ 16-17 years ☐ 18 years or older

Q6. If the patient is taking any strong or moderate cytocyrome P450 (CYP450) 3A4 inhibitors, (e.g., 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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Fentanyl-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:**

Q7. The plan has the following quantity limits in place: 120 per 30 days. Will the patient require a quantity 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:
Forteo-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 the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication: *
☐ Osteoporosis (glucocorticoid-induced)
☐ Osteoporosis (primary or hypogonadal)
☐ Osteoporosis (postmenopausal)
☐ Other

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

Q5. Has the patient experienced a prior fragility fracture?
☐ Yes ☐ No

Q6. Has the patient had an inadequate response to an adequate trial of a bisphosphonate (one year), OR has a contraindication or intolerance to a bisphosphonate trial?
☐ Yes ☐ No

Q7. Does the patient have any of the following risk factors for fracture (please select all that apply)?
☐ Advanced age

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Forteo-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
- ☐ Rheumatoid arthritis
- ☐ Chronic steroid use
- ☐ Other secondary cause of Osteoporosis
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gilotrif-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:
☐ 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 diagnosis is OTHER, please specify.

Q6. Do the patient's tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a Food and Drug Administration–approved test?
☐ Yes ☐ No

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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gilotrif-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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gocovri-4 Medicare

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

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Gonadotropin-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:
- ☐ Cryptorchidism (prepubertal)
- ☐ Hypogonadotropic hypogonadism (secondary to pituitary deficiency)
- ☐ Ovulation induction
- ☐ Assisted reproductive technology
- ☐ Other

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

Q5. Is the patient male or female?
☐ Male ☐ Female

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Gonadotropin-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:

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 start date (MM/YY):

Q3. 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 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

Q4. If the diagnosis is 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

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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:**

☐ None of the above

Q5. If the diagnosis is 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

Q6. If the diagnosis is GHD IN NEONATES WITH HYPOGLYCEMIA, please select all that apply:

- ☐ 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

Q7. For ADULT GHD, please select all of the following that apply to this patient:

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

Q8. If the diagnosis is IDIOPATHIC SHORT STATUTE, has pediatric GHD been ruled out with at least one (1) stimulation test?

☐ Yes ☐ No

Q9. If the diagnosis is OTHER, please specify below:

Q10. Please select the prescriber's specialty below:

- ☐ Endocrinologist
- ☐ Gastroenterologist
- ☐ Infectious Disease (ID) Specialist
- ☐ Nutritional Support Specialist
- ☐ Pediatric Nephrologist
- ☐ Other

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

Q12. Please indicate the patient's age below:

☐ Under 2 years of age

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:**

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

Q13. For PEDIATRIC PATIENTS, please select all that apply:

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

Q14. If the diagnosis is PEDIATRIC GHD, does the patient have pituitary disease or CNS disorder?

☐ Yes ☐ No

Q15. If the diagnosis is PEDIATRIC GHD, please select all that apply:

- ☐ Patient has delayed bone age
- ☐ Patient has failed 2 stimulation tests
- ☐ Patient has clinical evidence of GHD and low IGF-1/IGFBP3
- ☐ None of the above

Q16. If the diagnosis is TURNER SYNDROME, has the diagnosis been confirmed by genetic testing?

☐ Yes ☐ No

Q17. For CONTINUING THERAPY (ADULT PATIENTS), please select all that apply:

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

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Hepatitis B-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. 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 hepatitis B virus (HBV), with compensated liver disease

☐ Other

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

Q5. Please indicate the prescriber's specialty:

☐ Gastroenterologist

☐ Hepatologist

☐ Infectious disease specialist

☐ None of the above

Q6. Has the prescriber submitted documentation of immune-active chronic hepatitis B per AASLD guidelines?

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Hepatitis B-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:

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 virus (HCV) infection ☐ 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 indicate the prescriber's specialty:

☐ Gastroenterologist
☐ Hepatologist
☐ Infectious Disease Specialist
☐ Other

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

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 genotype and (for genotype 1 and 4) the patient's subtype (confirmed by HCV RNA level within the last 6 months):

Q9. For GENOTYPES 1 AND 4, if the request is for EPCLUSA, has the patient tried and failed (or has a contraindication or intolerance to) Zepatier or Mavyret?

☐ Yes ☐ No

Q10. Has the prescriber submitted laboratory results within 12 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR, 6) Serum Creatinine, and 7) GFR?

☐ Yes ☐ No

Q11. Does the patient have HIV co-infection?

☐ Yes ☐ No

Q12. Please indicate the patient's cirrhosis status below:

☐ Compensated cirrhosis (Child-Pugh class A)
☐ Decompensated cirrhosis (Child-Pugh class B or C)
☐ Patient does not have cirrhosis

Q13. Is the patient treatment naïve or treatment experienced?

☐ Treatment naïve ☐ Treatment experienced

Q14. For TREATMENT EXPERIENCED patients, please list all previous treatment regimens (along with the dates of treatment) and the patient's response to treatment (for example, non-responder, relapser, etc):

Q15. Please list all Hepatitis C medications the patient will be taking, along with the anticipated duration of treatment:

Q16. Does the patient have baseline NS5A polymorphisms?

☐ Yes ☐ No

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:**
Prescriber Signature	Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepsera-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 start date (MM/YY):

Q3. What is the patient's diagnosis for the requested medication:
☐ Hepatitis B (chronic)
☐ Other

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

Q5. Is the patient 12 years of age or older?
☐ Yes ☐ No

Q6. Is the prescriber a Gastroenterologist, infectious disease specialist, or affiliated with an infectious disease or gastroenterology practice, or a primary care physician with experience in treating HBV?
☐ Yes ☐ No

Q7. Has the patient had evidence of a positive HBsAG (+ or -) serological marker for greater than 6 months?
☐ Yes ☐ No

Q8. Does the patient have liver biopsy showing chronic hepatitis?
☐ Yes ☐ No

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Hepsera-3 Medicare

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Patient Name:	**Prescriber Name:**

Q9. Is the Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies per mL)?
☐ Yes ☐ No

Q10. Does the patient have HBeAg-negative HBV?
☐ Yes ☐ No

Q11. Is the Hepatitis B viral load greater than 2,000 IU per mL (10,000 copies per mL)?
☐ Yes ☐ No

Q12. Does the patient have elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal?
☐ Yes ☐ No

Q13. Does the patient have normal liver aminotransferases (ALT or AST) levels with evidence of significant disease found on biopsy?
☐ Yes ☐ No

Q14. Is the patient receiving Intron A?
☐ Yes ☐ No

Q15. For CONTINUATION THERAPY: Is there documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases?
☐ Yes ☐ No

Q16. Is the patient currently taking/receiving tenofovir or PMPA?
☐ Yes ☐ No

Q17. Does the patient have renal impairment? (Dose to be reduced to 10mg every 48 hours for CrCl 30 to 49mL/min, 10mg every 72 hours for CrCl 10 to 29mL/min).
☐ Yes ☐ No

Q18. Please provide the following: documented evidence (i.e. lab results) of diagnosis, serological markers or liver biopsy, viral load and liver aminotransferases.

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepsera-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:**

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

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

Q5. Does the patient have documented blindness?
☐ Yes ☐ No

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hetlioz-1 Medicare

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

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

Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

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:
☐ ADHD ☐ Hypertension ☐ Other

Q5. If the diagnosis is OTHER, please specify.

Prescriber Signature

Date

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:**

ENVISIONRx

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
☐ Short-Term Pain
☐ Osteoarthritis
☐ Gout
☐ 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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or 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. 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
- ☐ Insomnia
- ☐ Pruritis
- ☐ 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. Is the patient 65 years of age or older?

☐ Yes ☐ No

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

☐ Pruritus/Allergic conditions
☐ Sedation
☐ Anxiety/tension
☐ Nausea/Vomiting
☐ Motion sickness
☐ Adjunct to analgesia
☐ Other

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

Q6. FOR PRESCRIBER INFORMATION ONLY: Formulary non-HRM alternatives are as follows: Nausea/Vomiting: granisetron, ondansetron. Allergic Reactions: levocetirizine

ENVISIONRx

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HRM Antiemetics-3 Medicare

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

Patient Name:	**Prescriber Name:**

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 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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antihypertensives-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:

☐ Hypertension ☐ 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: Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions.

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Antihypertensives-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 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
☐ Drug-induced extrapyramidal symptoms (except tardive dyskinesia)
☐ 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

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

Prescriber Signature

Date

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:**

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.

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, Namenda XR, 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 patient's diagnosis below:

- ☐ Menopausal Symptoms
- ☐ Vulvar/Vaginal atrophy
- ☐ Prostate Cancer (Palliative Care)
- ☐ Breast Cancer (Palliative Care)
- ☐ Postmenopausal osteoporosis
- ☐ 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: Localized options: Premarin Cream and Estrace Cream. Osteoporosis: Alendronate, Risedronate, Zoledronic Acid.

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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Muscle Relaxant-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 medication requested:

- ☐ Cyclobenzaprine
- ☐ Chlorzoxazone
- ☐ Metaxalone
- ☐ Methocarbamol
- ☐ Orphenadrine

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

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

Q5. FOR Chronic painful musculoskeletal conditions, is the medication for daily use or intermittent use (no more than 2-3 weeks per episode)?

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

HRM Muscle Relaxant-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:**

☐ Chronic daily use
☐ Chronic intermittent use (no more than 2-3 weeks per episode)
☐ None of the above (medication is not being used chronically)

Q6. If the patient's 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 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 chronic illness
☐ 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

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

☐ 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

Prescriber Signature

Date

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:**

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 THEARPY, 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:
☐ Ankylosing Spondylitis (AS)
☐ Crohn's Disease (moderate to severe)
☐ Hidradenitis suppurativa (moderate to severe)
☐ Polyarticular juvenile idiopathic arthritis (pJIA) (moderate to severe)
☐ Plaque psoriasis (moderate to severe)
☐ Psoriatic arthritis (PsA)
☐ Rheumatoid arthritis (RA) (moderate to severe)
☐ Ulcerative Colitis (moderate to severe)
☐ Uveitis (non-infectious, intermediate, posterior, or panuveitis)
☐ Other

Q5. For CROHN'S DISEASE, please select all that apply to this patient:
☐ The patient has had an inadequate response to at least a 60-day trial of 2 conventional therapies (such as sulfasalazine, mesalamine, azathioprine, or corticosteroids)

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:**

☐ The patient has a contraindication or intolerance to conventional therapies
☐ The patient has had an inadequate response or intolerance to either Remicade or Cimzia
☐ None of the above

Q6. For POLYARTICULAR JIA, please select all that apply to this patient:
☐ The patient has had an inadequate response to at least one nonbiologic DMARD
☐ The patient has had and intolerance or contraindication to at least 2 nonbiologic DMARDs
☐ None of the above

Q7. For PLAQUE PSORIASIS, please select all that apply to this patient:
☐ The patient's disease affects greater than 5% of the body surface area (BSA) or affects crucial body areas such as the feet, hands, face or genitals
☐ The patient has had an inadequate response to at least a 60-day trial of 2 conventional therapies (such as phototherapy, calcipotriene, MTX, acitretin)
☐ Conventional therapies are contraindicated for this patient
☐ None of the above

Q8. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q9. For PSORIATIC ARTHRITIS, has the patient had an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy?
☐ Yes ☐ No

Q10. For RHEUMATOID ARTHRITIS, please select all that apply to this patient:
☐ The patient has had an inadequate response to methotrexate (MTX)
☐ The patient has had an inadequate response to another nonbiologic DMARD (such as leflunomide, hydroxychloroquine, or sulfasalazine) if there is a contraindication or intolerance to MTX
☐ The patient has had an intolerance or contraindication to at least 2 nonbiologic DMARDs
☐ Humira being used as first-line therapy with MTX for severely active RA
☐ None of the above

Q11. If the patient's diagnosis is OTHER, please specify below:

Q12. Will the patient be using Humira in combination with other biologics?
☐ Yes ☐ No

Q13. Does the patient have any active infections (including tuberculosis [TB])?
☐ Yes ☐ No

Q14. Has the patient been screened for latent TB infection (LTBI) and if positive, the patient has completed treatment or is currently receiving treatment?

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:**

☐ Yes ☐ No

Q15. Has the patient been assessed for Hepatitis B virus (HBV) risk and HVB infection has been ruled out (or treatment has been initiated for positive infection)?

☐ Yes ☐ No

Prescriber Signature

Date

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 Start Date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Breast cancer, advanced or metastatic (initial endocrine-based therapy)
☐ Breast cancer, advanced or metastatic (second-line endocrine-based therapy)
☐ Other

Q4. Is the patient a post-menopausal female?
☐ Yes ☐ No

Q5. Did the patient experience disease progression following previous endocrine based therapy?
☐ Yes ☐ No

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

Q7. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?
☐ Yes ☐ No

Q8. Will any of the following medications be used in combination with Ibrance (please select all that apply)?

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:**

☐ Aromatase inhibitor such as letrozole (Femara)
☐ Fulvestrant (Faslodex)
☐ None of the above

Q9. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q10. 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 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 Specialty:
☐ Hematologist ☐ Oncologist ☐ Other

Q7. If Prescriber Specialty is Other, please specify:

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-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:
☐ 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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Idhifa-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:

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 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:
Imfinzi-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:
☐ Urothelial carcinoma (locally advanced or metastatic)
☐ Other

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

Q5. Has the patient experienced disease progression during or following platinum-containing chemotherapy, or disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy?
☐ 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?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Imfinzi-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
☐ Other

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

Q5. Is the patient between 2 and 20 years of age?
☐ Yes ☐ No

Q6. Is the prescriber an Endocrinologist?
☐ Yes ☐ No

Q7. Prior to starting therapy, is the patient's height greater than 3 standard deviations (SD) below the mean for chronological age and sex?
☐ Yes ☐ No

Q8. Is the patient's IGF-1 level greater than or equal to 3 standard deviations below the mean for chronological age

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:**

and gender?

☐ Yes ☐ No

Q9. Does the patient have one stimulation test showing patient has a normal or elevated GH levels?

☐ Yes ☐ No

Q10. Are the patient's epiphyses closed?

☐ Yes ☐ No

Q11. Will Increlex be administered intravenously?

☐ Yes ☐ No

Q12. Does the patient have active or suspected malignancy?

☐ 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 which medication this request is for:
☐ Itraconazole capsules
☐ Sporanox solution

Q4. Please indicate the diagnosis for which Itraconzole is being requested: *
☐ Blastomycosis (pulmonary or extrapulmonary)
☐ Histoplasmosis (including chronic cavitary pulmonary disease or disseminated, non-meningeal histoplasmosis)
☐ Aspergillosis (pulmonary or extra pulmonary)
☐ Onychomycosis of the toenail, with or without finger nail involvement, due to dermatophytes (tinea unguium)
☐ Onychomychosis of the fingernail due to dermatophytes (tinea unguium)
☐ Oropharyngeal/esophageal candidiasis
☐ Other

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

Q6. For ONYCHOMYCHOSIS, has the diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)?

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:**

☐ Yes ☐ No

Q7. Does the patient have ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF)?

☐ Yes ☐ No

Q8. Is the patient is currently taking any drugs metabolized by CYP3A4 (e.g., cisapride, dofetilide, pimozide, quinidine)?

☐ Yes ☐ No

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. 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:

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

Q4. Is the patient's condition being caused by menopause?

☐ Yes ☐ No

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)?

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

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:**

Prescriber Signature

Date

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
☐ Hepatitis A, Prophylaxis
☐ Other

Q4. For CIDP: Has diagnosis been confirmed by a neurologist?
☐ Yes ☐ No

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

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

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:**

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

Q3. Please indicate the patient's diagnosis below:
☐ Homozygous familial hypercholesterolemia
☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Has the patient had an inadequate response or intolerance to statins (e.g. atorvastatin, pravastatin, simvastatin)?
☐ 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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or 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, in patients with Confirmed G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H mutation in the CFTR gene
☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. For CONTINUING THERAPY: Has the patient experienced one of the following while on Kalydeco therapy: Improved lung function or stable lung function?
☐ Yes ☐ No

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:
Kanuma-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: *
☐ Lysosomal acid lipase (LAL) deficiency
☐ Other

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

Q5. Is the requested medication being prescribed by a hepatologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kanuma-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:
Keytruda-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 the 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: *
- ☐ Melanoma (unresectable or metastatic)
- ☐ Non-small cell lung cancer (NSCLC) (metastatic)
- ☐ Hodgkin lymphoma, classical (refractory or relapsed)
- ☐ Non-small cell lung cancer (NSCLC) (metastatic nonsquamous)
- ☐ Squamous cell carcinoma of the head and neck (recurrent or metastatic)
- ☐ Urothelial carcinoma (locally advanced or metastatic)
- ☐ Unresectable or metastatic solid tumors that have been identified as having a biomarker referred to as microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)
- ☐ Recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma
- ☐ Other

Q4. For NON-SMALL CELL LUNG CANCER, is Keytruda being used as first-line therapy?
☐ Yes ☐ No

Q5. For NON-SMALL CELL LUNG CANCER, please select which of the following apply to this patient.
- ☐ Patient has high PD-L1 expressing tumors
- ☐ Patients has PD-L1 expression with disease progression

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Keytruda-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:**

☐ None of the above

Q6. For NON-SMALL CELL LUNG CANCER, does the patient have EGFR or ALK genomic tumor aberrations?

☐ Yes ☐ No

Q7. FOR NON-SMALL CELL LUNG CANCER, has the patient experienced disease progression on any of the following (please select all that apply)?

☐ Platinum-based chemotherapy
☐ EGFR- or ALK-directed therapy
☐ None of the above

Q8. For HODGKIN LYMPHOMA, is the patient's disease refractory to or has relapsed after 3 or more prior lines of therapy?

☐ Yes ☐ No

Q9. For NONSQUAMOUS NON-SMALL CELL LUNG CANCER, is Keytruda being used as first-line therapy in combination with pemetrexed and carboplatin?

☐ Yes ☐ No

Q10. For SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK, has the patient experienced disease progression on or after platinum-based chemotherapy?

☐ Yes ☐ No

Q11. For UROTHELIAL CARCINOMA, please select if any of the following apply to this patient.

☐ The patient is not eligible for cisplatin-containing treatment
☐ The patient experienced disease progression during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy
☐ None of the above

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

Q13. FOR GASTRIC or GASTROESOPHAGEAL junction adenocarcinoma, please check all that apply:

☐ Tumors express PD-L1 as determined by an FDA-approved test
☐ Disease progression on or after two or more prior lines of therapy including fluoropyrimidine-and platinum-containing chemotherapy
☐ Disease progression on or after appropriate HER2 neu-targeted therapy
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Keytruda-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:
Kineret-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, has the patient's condition improved or stabilized?
☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis for the requested medication:
☐ Cryopyrin-associated periodic syndromes (CAPS) with neonatal-onset multisystem inflammatory disease (NOMID)
☐ Rheumatoid arthritis (RA) (moderately to severely active)
☐ Other

Q5. For RHEUMATOID ARTHRITIS, please select all that apply to this patient:
☐ Patient had an inadequate response to methotrexate (MTX)
☐ Patient had an inadequate response to another non-biologic DMARD (such as leflunomide, hydroxychloroquine, or sulfasalazine) if MTX is contraindicated or not tolerated
☐ Patient had an intolerance or contraindication to at least 2 non-biologic DMARDs
☐ Kineret will be used as first-line therapy with MTX for severely active RA
☐ None of the above

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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Kineret-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 Kineret be used concurrently with other biologics?

☐ Yes ☐ No

Q8. Does the patient have any active infections?

☐ Yes ☐ No

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. 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. Please select all that apply to this patient:
☐ The patient is a postmenopausal female
☐ The patient's disease is hormone receptor (HR)-positive
☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative
☐ Kisqali will be used in combination with an aromatase inhibitor (e.g. anastrozole, exemestane, letrozole)
☐ 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?
☐ Yes ☐ No

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

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:**

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

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 this medication *
☐ Hyperglycemia - Idiopathic Cushing's syndrome, in patients who have failed surgery or are ineligible for surgery
☐ Other

Q4. If the 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?

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:**

☐ Yes ☐ No

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

☐ 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. 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:
☐ Homozygous familial hypercholesterolemia
☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Has the patient tried and failed or had an intolerance to statins (e.g. atorvastatin, pravastatin, simvastatin)?
☐ 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:
Lartruvo-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:
☐ Soft tissue sarcoma (STS)
☐ Other

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

Q5. Please select all that apply to this patient:
☐ The patient has a histologic subtype for which an anthracycline-containing regimen is appropriate
☐ The patient had previous treatment failure with radiotherapy or surgery
☐ The patient will use Lartruvo in combination with doxorubicin for the first 8 cycles of treatment
☐ None of the above

Q6. Is the requested medication being prescribed by an oncologist?
☐ Yes ☐ No

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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lartruvo-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. 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
☐ The patient 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

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:**

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, does the patient have excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood?
☐ Yes ☐ No

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

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

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:**

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

Prescriber Signature

Date

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:**

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Lidocaine Patch-1 Medicare

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

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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

Q7. If medication is OTHER, please specify:

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)?

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:**

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupron-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 which medication the request is for:

- ☐ Lupron Depot - Pediatric Injection 7.5 mg
- ☐ Lupron Depot - Pediatric Injection 11.25
- ☐ Lupron Depot - Pediatric Injection 15 mg
- ☐ Lupron Depot Injection 3.75 mg
- ☐ Lupron Depot Injection 7.5 mg
- ☐ Lupron Depot Injection 22.5 mg
- ☐ Lupron Depot Injection 30 mg
- ☐ Lupron Depot Injection 45 mg

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

- ☐ Prostate cancer (advanced or metastatic)
- ☐ Endometriosis
- ☐ Anemia due to uterine Leiomyomata (Fibroids)
- ☐ Central precocious puberty
- ☐ Other

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupron-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 ENDOMETRIOSIS, has the patient had an inadequate pain control response, intolerance or contraindication to any of the following? (please select all that apply):

- ☐ Danazol
- ☐ Combination (estrogen/progesterone) oral contraceptives
- ☐ Progestin
- ☐ Other

Q6. If medication is other, please specify below:

Q7. For ANEMIA DUE TO UTERINE LEIOMYOMATA (FIBROIDS), please select all that apply:

- ☐ Patient is preoperative
- ☐ None of the above

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

Q9. For RETREATMENT OF ENDOMETRIOSIS, please select all that apply:

- ☐ Patient is experiencing recurrence of symptoms after an initial course of therapy with leuprolide acetate
- ☐ Norethindrone acetate 5 mg daily will be co-administered
- ☐ None of the above

Q10. For FEMALE PATIENTS, select all that apply:

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

Q11. Will the patient be utilizing non-hormonal contraceptives during and for 12 weeks after therapy?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Lupron-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:
Lynparza-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, advanced
☐ Other

Q4. If diagnosis is OTHER, please specify below:

Q5. Does the patient have deleterious or suspected deleterious germline BRCA mutation as detected by an FDA approved test?
☐ Yes ☐ No

Q6. Has the patient been treated with three (3) or more prior lines of chemotherapy?
☐ Yes ☐ No

Q7. If the patient has NOT been treated with three (3) or more prior lines of chemotherapy, is there a reason that Lynparza is preferred over these alternatives?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Lynparza-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:

Makena/Hydroxyprogesterone-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:

☐ Preterm labor prevention, (singleton pregnancy)

☐ Other

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

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

☐ Yes ☐ No

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

☐ Breast, cervical, hepatocellular, uterine, or vaginal cancer

☐ Hepatic or thromboembolic disease

☐ Jaundice

☐ Vaginal bleeding

☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Makena/Hydroxyprogesterone-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:
Mavyret-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 hepatitis C virus (HCV) infection
☐ Other

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

Q5. Please provide the patient's genotype and subtype confirmed by HCV RNA level within the last 6 months (must submit documentation):

Q6. Please indicate the prescriber's specialty:
☐ Gastroenterologist
☐ Hepatologist
☐ Infectious Disease Specialist
☐ Other

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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mavyret-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 patient 18 years of age or older?

☐ Yes ☐ No

Q9. Has the patient tried and failed (or had an intolerance or contraindication to) any of the following (please select all that apply)?

☐ Harvoni ☐ Zepatier ☐ None of the above

Q10. Does the prescriber agree to submit laboratory results within 6 weeks of initiating therapy including: 1) CBC with Platelets, 2) AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR, 6) Serum Creatinine, and 7) GFR?

☐ Yes ☐ No

Q11. Please select the patient's cirrhosis status below:

☐ The patient does not have cirrhosis
☐ The patient has compensated cirrhosis (Child-Pugh A)
☐ Other

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

Q13. Is the patient treatment-naïve or treatment experienced?

☐ Treatment-naïve
☐ Treatment experienced

Q14. If the patient is treatment experienced, please select which of the following regimens the patient has previously tried and failed (or has a contraindications or intolerance to):

☐ NS5A inhibitor containing regimen without an NS3/4A protease inhibitor
☐ NS3/4A protease inhibitor containing regimen without an NS5A inhibitor
☐ Interferon, ribavirin, and/or sofosbuvir containing regimens, but no prior treatment with an NS3/4A protease inhibitor or NS5A inhibitor
☐ Other

Q15. Please list all previous HCV medication regimens the patient has tried and the response to therapy:

COVERAGE DETERMINATION REQUEST FORM

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

Q3. Please indicate the patient's diagnosis below:
☐ Autologus stem cell transplantation for the treatment of non-Hodgkin's lymphoma or multiple myeloma
☐ Other

Q4. If diagnosis is OTHER, please specify:

Q5. Will the patient concomitantly receive a daily dose of a granulocyte colony-stimulating factor (G-CSF) for 4 days prior to the first evening dose of Mozobil and on each day prior to apheresis while using Mozobil?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mozobil-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:
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. If the request is 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
☐ Copaxone
☐ Gilenya
☐ Plegridy
☐ Tecfidera

Q5. Do any of the following apply to this patient (please select all that apply)?
☐ Patient has severe hepatic impairment
☐ Patient is currently being treated with leflunomide
☐ Patient is pregnant
☐ Patient is a woman of child-bearing potential who is NOT using reliable contraception

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:**

☐ None of the above

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

☐ 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. 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. 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

Q9. If the patient's diagnosis is OTHER, please specify below:

Q10. Is the patient 18 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mylotarg-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 OF NEWLY DIAGNOSED AML, has the patient exceeded a maximum of 8 cycles?

☐ Yes ☐ No

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

☐ Acute myeloid leukemia (AML) (newly diagnosed)
☐ Acute myeloid leukemia (AML) (relapsed or refractory)
☐ Other

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

Q6. Is the patient's disease CD33-positive?

☐ Yes ☐ No

Q7. Please indicate the patient's age below:

☐ Under 2 years ☐ 2-17 years ☐ 18 years or older

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Mylotarg-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 medication prescribed by (or in consultation with) an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Naglazyme-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 continuation therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Replacement therapy in mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy Syndrome) for improvement of walking and stair-climbing capacity

☐ Other

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

Q5. Has the diagnosis confirmed by DNA testing or an enzymatic assay showing a deficiency in N-acetylgalactosamine activity?

☐ Yes ☐ No

Q6. Does the patient have at least one MPS VI symptom?

☐ Yes ☐ No

Q7. FOR CONTINUATION THERAPY: Has the patient had improvement in walking and/or stair-climbing capacity?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Naglazyme-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:
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. 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 (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:
Neulasta-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 patient's diagnosis for the requested medication below:
☐ Prevention of chemotherapy-induced neutropenia (non-myeloid malignancies)
☐ Other

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

Q5. For prevention of chemotherapy-induced febrile neutropenia please answer the following (select all that apply):
☐ 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
☐ None of the above

Q6. Are the patient's complete blood count and platelet count being monitored at baseline, and a regularly thereafter?
☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Neulasta-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. Please indicate if the patient has any of the following (select all that apply):

- ☐ Treatment of febrile neutropenia
- ☐ Known hypersensitivity to filgrastim
- ☐ Use in the period 14 days before and 24 hours after administration of chemotherapy
- ☐ Use in patients with myeloid malignancy
- ☐ Use to increase the chemotherapy dose intensity or dose schedule beyond established regimens
- ☐ None of the above

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Neupogen-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 below: *

- ☐ Acute myeloid leukemia patients following induction or consolidation chemotherapy
- ☐ Bone marrow transplantation
- ☐ Hematopoietic radiation injury syndrome, acute
- ☐ Myelosuppressive chemotherapy recipients with nonmyeloid malignancies
- ☐ Peripheral blood progenitor cell collection and therapy
- ☐ Severe chronic neutropenia
- ☐ 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 (or Leukine) OR in patients at risk for infection-related complications

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Neupogen-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

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):

- ☐ Treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle
- ☐ E. coli hypersensitivity
- ☐ Administration within 24 hours preceding or following chemotherapy or radiotherapy
- ☐ Use in patients with myeloid malignancy
- ☐ Use to increase the chemotherapy dose intensity or dose schedule beyond established regimens
- ☐ None of the above

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 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)?

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:**

- ☐ Orthostatic dizziness
- ☐ 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. If the patient's diagnosis is OTHER, please specify below:

Q5. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q6. For ASTHMA, does the patient have an eosinophilic phenotype?

☐ 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 start date (MM/YY):

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

☐ 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

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

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:

Prescriber Signature

Date

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:**

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opdivo-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: *

☐ Colorectal cancer, metastatic
☐ Head and neck cancer, squamous cell (recurrent or metastatic)
☐ Hepatocellular carcinoma
☐ Hodgkin lymphoma, classical
☐ Melanoma, unresectable or metastatic
☐ Non-small cell lung cancer (NSCLC), metastatic
☐ Renal cell carcinoma, advanced
☐ Urothelial carcinoma, locally advanced or metastatic
☐ Other

Q4. For COLORECTAL CANCER, please select all that apply to this patient:

☐ The patient's disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)
☐ The patient's disease has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan
☐ None of the above

Q5. For HEAD AND NECK CANCER, has the patient experienced disease progression on or after platinum-based chemotherapy?

☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opdivo-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. For HEPATOCELLULAR CARCINOMA, has the patient experienced disease progression on (or intolerance to) therapy with sorafenib (Nexavar)?

☐ Yes ☐ No

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

☐ The patient has relapsed or progressed after autologous hematopoietic stem cell transplant (HSCT) and brentuximab vedotin

☐ The patient has relapsed or progressed after 3 or more lines of systemic therapy that includes an autologous hematopoietic stem cell transplantation (HSCT)

☐ None of the above

Q8. For MELANOMA, does the patient have BRAF V600 wild-type or BRAF V600 mutation-positive disease?

☐ Yes ☐ No

Q9. For MELANOMA, please select if any of the following apply to this patient:

☐ Opdivo will be used as a single agent (monotherapy)

☐ Opdivo will be used in combination with ipilimumab (Yervoy)

☐ Opdivo will be used as adjuvant treatment of melanoma in patients with lymph node involvement or metastatic disease who have undergone complete resection

☐ None of the above

Q10. For NON-SMALL CELL LUNG CANCER, does the patient have EGFR or ALK genomic tumor aberrations?

☐ Yes ☐ No

Q11. For NON-SMALL CELL LUNG CANCER, please select if any of the following apply to this patient:

☐ The patient's disease has progressed on or after platinum-based chemotherapy

☐ The patient's disease has progressed on or after FDA-approved EGFR- or ALK-directed therapy

☐ None of the above

Q12. For RENAL CELL CANCER, please select all that apply to this patient:

☐ Opdivo will be used in combination with ipilimumab (Yervoy)

☐ Opdivo will be used as monotherapy and the patient has received prior anti-angiogenic therapy

☐ None of the above

Q13. For COLORECTAL CANCER, please select all that apply to this patient:

☐ The patient's disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)

☐ The patient's disease has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan

☐ None of the above

Q14. For UROTHELIAL CARCINOMA, please select if any of the following apply to this patient:

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opdivo-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:**

☐ The patient's disease has progressed on or following a platinum-containing therapy

☐ The patient's disease has progressed within 12 months of neoadjuvant or adjuvant treatment with a platinum-containing therapy

☐ None of the above

Q15. If the patient's diagnosis is OTHER, please specify below.

Q16. Is the patient 12 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Opioid Antagonist-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:

☐ Opioid Dependence ☐ Other

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

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Opioid Antagonist-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:
Opsumit-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 THEARPY, 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 I)
☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Opsumit-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:**

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orencia-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, has the patient's condition improved or stabilized?
☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis for the requested medication:
☐ Polyarticular juvenile idiopathic arthritis (pJIA) (moderately to severely active)
☐ Psoriatic arthritis (PsA)
☐ Rheumatoid arthritis (RA) (moderately to severely active)
☐ Other

Q5. For POLYARTICULAR JIA, please select all that apply to this patient:
☐ The patient has had an inadequate response to at least one non-biologic DMARD
☐ The patient has had an intolerance or contraindication to at least 2 non-biologic DMARDs
☐ None of the above

Q6. For RHEUMATOID ARTHRITIS, please select all that apply to this patient:
☐ The patient has had inadequate response to methotrexate (MTX)
☐ The patient has had an inadequate response to another non-biologic DMARD (such as leflunomide, hydroxychloroquine, or sulfasalazine) if MTX is contraindicated or the patient is intolerant

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orencia-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 an intolerance or contraindication to at least 2 non-biologic DMARDs
☐ Orencia will be used as first-line therapy for severely active RA
☐ None of the above

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

Q8. Will the patient be using Orencia in combination with other biologics?
☐ Yes ☐ No

Q9. Does the patient have any active infections (including tuberculosis [TB])?
☐ Yes ☐ No

Q10. Has the patient been screened for latent TB infection (LTBI) and if positive, the patient has completed treatment or is currently receiving treatment?
☐ Yes ☐ No

Q11. Has the patient been assessed for Hepatitis B virus (HBV) risk and HVB infection has been ruled out (or treatment has been initiated for positive infection)?
☐ Yes ☐ No

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 patient 6 years of age or older?

☐ Yes ☐ No

Q8. 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:
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. 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:

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

Q4. Is the patient's condition being caused by menopause?

☐ Yes ☐ No

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)?

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

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:**

☐ None of the above

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Oxsoralen-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 Oxsoralen is being requested:
☐ Cutaneous T-cell lymphoma
☐ Psoriasis
☐ Other

Q4. If the diagnosis is psoriasis, has the patient tried and failed, is intolerant to or has a contraindication to at least one topical steroid?
☐ Yes ☐ No

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

Q6. Does the patient have aphakia, melanoma or invasive squamous cell carcinoma?
☐ Yes ☐ No

Q7. Is the prescriber a Dermatologist, Oncologist or affiliated with a dermatologist/oncologist practice?
☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Oxsoralen-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:
PCSK9 Inhibitors-1 Medicare

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

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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:

☐ Heterozygous Familial Hypercholesterolemia (HeFH)
☐ Homozygous Familial Hypercholesterolemia (HoFH)
☐ Clinical Atherosclerotic Cardiovascular Disease (CVD)
☐ Other

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

☐ Genotyping
☐ Simon Broome criteria
☐ None of the above

Q6. FOR HeFH: if the diagnosis was confirmed by Simon Broome criteria, please select all that apply to this patient:

☐ Total cholesterol greater than 290 mg/dL
☐ LDL cholesterol greater than 190 mg/dL

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
PCSK9 Inhibitors-1 Medicare

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

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

Patient Name:	**Prescriber Name:**

☐ Tendon xanthomas in the patient, 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt)
☐ DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation
☐ None of the above

Q7. For HoFH, has the diagnosis been confirmed by any of the following? (please select all that apply):
☐ 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

Q8. 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

Q9. If the patient's diagnosis is OTHER, please specify below:

Q10. Please provide the patient's baseline and current LDL-C cholesterol levels below:

Q11. Please indicate the patient's age:
☐ Less than 13 years of age
☐ 13-17 years of age
☐ 18 years of age or older

Q12. 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 contraindicated or not tolerated by the patient
☐ None of the above

Q13. If statins are contraindicated or not tolerated by the patient, please explain below:

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

PCSK9 Inhibitors-1 Medicare

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

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

Patient Name:	**Prescriber Name:**

Q14. Is the medication being prescribed by, or in consultation, with any of the following provider specialties?

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

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

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

Prescriber Signature

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:

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:**

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:
Promacta-3 Medicare

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

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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, thrombocytopenia
- ☐ Severe aplastic anemia with insufficient response to immunosuppressive therapy
- ☐ Other

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

Q5. Has the patient been evaluated for other causes of thrombocytopenia AND has 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

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

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.**

Patient Name:	**Prescriber Name:**

☐ 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 a maximal 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:

Radicava-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:

☐ Amyotrophic lateral sclerosis (ALS) ☐ Other

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

Q5. Is Radicava being prescribed by (or in consultation with) a neurologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ The patient has maintained functionality for most activities of daily living (ADLs) (defined as scores of 2 points or better on each individual item of the ALS Functional Rating Scale)

☐ The patient has normal respiratory function (defined as forced vital capacity [FVC] greater than or equal to 80%)

☐ The patient's disease duration has been 2 years or less

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Radicava-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

Q8. Does the patient have sulfite hypersensitivity?

☐ 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 the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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:
Relistor-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:
☐ Opioid induced constipation
☐ Other

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

Q5. Please select any of the following that apply to this patient:
☐ Patient is an adult with chronic, non-cancer pain
☐ Patient is an adult with advanced illness who is receiving palliative care
☐ Patient has experienced an inadequate response to conventional laxative treatment
☐ None of the above

Q6. Does the patient have known or suspected mechanical gastrointestinal obstruction?
☐ Yes ☐ No

Q7. Has the patient tried and failed polyethylene glycol (Miralax)?
☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Relistor-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. If the patient has NOT tried polyethylene glycol (Miralax), is there a reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revatio-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:
☐ 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:
Revatio-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:
Revlimid-3 Medicare

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

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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: *
☐ Mantle cell lymphoma
☐ Multiple Myeloma
☐ Transfusion-dependent anemia
☐ Other

Q4. For MANTLE CELL LYMPHOMA, has the patient relapsed or progressed after two (2) prior therapies (one of which included bortezomib)?
☐ Yes ☐ No

Q5. For MULTIPLE MYELOMA, please select all that apply:
☐ Patient has received at least one prior therapy
☐ Revlimid will be used in combination with dexamethasone
☐ None of the above

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?

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Revlimid-3 Medicare

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

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

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

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

Q8. Is the patient enrolled in the Revlimid REMS Program?
☐ Yes ☐ No

Q9. Is the patient pregnant?
☐ Yes ☐ No

Q10. Have male and female patients of child-bearing potential been instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use?
☐ Yes ☐ No

Q11. Will the patient be monitored for signs and symptoms of thromboembolism?
☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rexulti-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 for the requested medication:
☐ Major depressive disorder, In combination with antidepressants
☐ Schizophrenia
☐ Other

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

Q5. Has the patient tried and failed aripiprazole?
☐ Yes ☐ No

Q6. If the patient has NOT tried aripiprazole, is there a reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rexulti-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:
Ribavirin-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 Hepatits C ☐ Other

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

Q5. For CHRONIC HEPATITIS C, please indicate the patient's genotype below:

Q6. Please indicate the prescriber's specialty:
☐ Infectious disease (ID)
☐ Gastroenterology
☐ Oncology
☐ Other

Q7. If the prescriber specialty is Other, please describe below:

Q8. REQUIRED: Please submit chart notes/written medical summary documenting the diagnosis of chronic hepatitis C

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ribavirin-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:**

as well as recent lab reports documenting elevated HCV RNA and genotype. Have these been submitted with this request (please check off all that have been submitted)?

- ☐ Chart notes/medical summary documenting diagnosis of chronic hepatitis C
- ☐ Recent lab reports documenting elevated HCV RNA
- ☐ Recent lab reports documenting patient's genotype
- ☐ None of the above have been submitted

Q9. Please select if any of the following apply to this patient:

- ☐ Hemoglobin less than 8.5 g/dL
- ☐ Hemoglobinopathy
- ☐ History of unstable heart disease
- ☐ Creatinine clearance less than 50 mL/minute and unwilling to use modified dose of ribavirin
- ☐ Pregnancy (self or partner)
- ☐ Unwilling to use effective contraception
- ☐ Co-administration with didanosine in HIV co-infected patients
- ☐ None of the above

Q10. Has the patient been instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rituxan-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 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:
☐ Non-Hodgkin lymphoma
☐ Rheumatoid Arthritis (RA)
☐ Chronic lymphocytic leukemia
☐ Microscopic polyangiitis
☐ Wegener granulomatosis
☐ Induction therapy for Burkitt's lymphoma
☐ Other

Q4. If treating a Hematologic Malignancy, is the malignancy CD20 positive ?
☐ Yes ☐ No

Q5. If the request is for Rheumatoid Arthritis, has the patient had an inadequate response, or intolerance to methotrexate?
☐ Yes ☐ No

Q6. If the patient has a contraindication to Methotrexate therapy, please indicate which of the following the patient has tried and failed:

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rituxan-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:**

- ☐ Cyclosporine
- ☐ Azulfidine/Sulfasalazine
- ☐ Hydroxychloroquine
- ☐ Leflunomide
- ☐ Azathioprine
- ☐ Other
- ☐ None of the above

Q7. If medication is Other, please specify:

Q8. If the diagnosis is Severely active rheumatoid arthritis warranting frontline Rituxan therapy, please indicate below which therapies the patient has had an inadequate response to:

- ☐ Enbrel
- ☐ Humira
- ☐ Kineret
- ☐ Remicade
- ☐ None of the above

Q9. If the patient's diagnosis is OTHER, please specify below:

Q10. For CONTINUING RA therapy: has patient shown improvement in clinical symptoms (may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease) from the last treatment course (at least 16 weeks earlier)?

☐ Yes ☐ No

Q11. Will Rituxan be used in combination with chemotherapy (or other agents) for mantle cell lymphoma, Burkitt's lymphoma, lymphoblastic lymphoma, or AIDS-related B-cell lymphoma?

☐ Yes ☐ No ☐ Not Applicable

Q12. Has the patient been assessed for hepatitis B risk prior to initiation of therapy and, if appropriate, ruled out or initiated treatment for hepatitis B?

☐ Yes ☐ No

Q13. Does the patient have a history of severe skin or infusion reaction with Rituxan that cannot be appropriately managed?

☐ Yes ☐ No

Q14. Will Rituxan be used in combination with another biologic agent?

☐ Yes ☐ No

Q15. Is the patient being monitored for pulmonary toxicity?

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Rituxan-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:
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

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:**

- ☐ 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?
☐ Yes ☐ No

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:**

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

Q8. Will Samsca be used in combination with a strong CYP3A inhibitor (such as clarithromycin or ketoconazole)?

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:**

☐ 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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sandostatin-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 diagnosis for which Sandostatin (octreotide) is being requested:
☐ Metastatic carcinoid tumors
☐ Watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas)
☐ Acromegaly
☐ Other

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

Q5. Has the patient received initial treatment with Sandostatin Injection (not the Depot form) for at least 2 weeks and treatment with Sandostatin Injection was effective and tolerable?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Sandostatin-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:
Serostim-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 request for initial or continuation therapy?
☐ Initial therapy ☐ Continuing therapy

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

Q3. Please indicate the diagnosis for which Serostim is being requested:
☐ HIV-Associated Wasting or Cachexia
☐ Other

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

Q5. Is the patient on concurrent antiretroviral therapy?
☐ Yes ☐ No

Q6. Have alternative causes of wasting have been ruled out or treated appropriately?
☐ Yes ☐ No

Q7. Does the patient have history of an acute critical illness or active malignancy?
☐ Yes ☐ No

Q8. For CONTINUATION THERAPY (treated for 12 or more weeks): has the patient's body mass index has improved or stabilized?
☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Serostim-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:

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

☐ 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?

☐ Yes ☐ No

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:**

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Somavert-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:
☐ Acromegaly in patients who have had an inadequate response to surgery, radiation therapy, or other medical therapies, or for whom these therapies are inappropriate
☐ 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-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
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:
Soriatane-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 below:
☐ Psoriasis (severe) ☐ Other

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

Q5. Do any of the following apply to this patient? (check all that apply):
- ☐ Severely impaired liver function
- ☐ Severely impaired kidney function
- ☐ Chronic abnormally elevated blood lipid value
- ☐ Patient is currently taking methotrexate
- ☐ Patient is currently taking tetracycline
- ☐ None of the above

Q6. If the patient is female and able to bear children (e.g., no hysterectomy, not reached menopause, has achieved menses): has pregnancy been excluded (as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL)?
☐ Yes

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Soriatane-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
☐ Patient is not female or is unable to bear children

Q7. FOR FEMALES: please indicate the forms of birth control that the patient will use during therapy with acitretin (requires one primary form (e.g., tubal ligation, partner's vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) PLUS one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide OR absolute abstinence.

Q8. FOR FEMALES: has the patient agreed to use her chosen form of contraception for at least 1 month before initiation of acitretin therapy, during acitretin therapy, and for at least 3 years after discontinuation of therapy?

☐ Yes ☐ No

Q9. FOR FEMALES: has the patient been advised that ethanol must not be ingested by female patients during acitretin treatment and for 2 months following therapy?

☐ Yes ☐ No

Q10. FOR FEMALES: has the patient agreed to have a pregnancy test on a monthly basis?

☐ Yes ☐ No

Q11. Has the female and/or guardian signed a Patient Agreement/Informed Consent?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-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:
☐ 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

Q6. If medication is Other, please specify:

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Stivarga-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 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:

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 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-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 the patient's diagnosis below:
☐ Diabetes mellitus type 1, adjunctive treatment
☐ Diabetes mellitus type 2, adjunctive treatment
☐ Other

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

Q5. FOR INITIAL THERAPY: Does the patient have inadequate glycemic control (HbA1c greater than 7% but less than 9%) at initiation of therapy AND currently receiving optimal mealtime insulin therapy?
☐ Yes ☐ No

Q6. FOR CONTINUING THERAPY: If the patient has taken Symlin in previous 6 months, have they demonstrated a reduction in HbA1c since initiating Symlin therapy?
☐ Yes
☐ No
☐ Patient has not taken Symlin in the past 6 months

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Symlin-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. Please indicate if any of the following apply to the patient:

- ☐ Severe hypoglycemia that required assistance during the past 6 months
- ☐ Gastroparesis
- ☐ Patient requires drug therapy to stimulate gastrointestinal motility
- ☐ Hypoglycemia unawareness (i.e. inability to detect and act upon the signs or symptoms of hypoglycemia)
- ☐ None of the above

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
☐ Absence of endogenous testosterone

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:**

☐ None of the above

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
☐ Aphthous ulcers
☐ Waldenstrom macroglobulinemia
☐ Graft versus host disease
☐ Primary brain tumor
☐ Ankylosing Spondylitis
☐ Other

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

Q5. Is the requested medication being prescribed by an oncologist?
☐ Yes ☐ No

Q6. If the diagnosis is multiple myeloma, will the patient receive concurrent dexamethasone?

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

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?

☐ 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:

Topical Immunosuppressants-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 for the requested medication: *

☐ Atopic dermatitis ☐ Other

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

Q5. Please indicate which medication this request is for:

☐ Elidel Cream 1%
☐ Tacrolimus Ointment 0.03%
☐ Tacrolimus Ointment 0.1%

Q6. Please indicate the patient's age:

☐ Under 2 years of age
☐ 2-15 years of age
☐ 16 years of age or older

Q7. Has the patient tried and failed at least TWO (2) medium or higher potency topical steroids?

☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Topical Immunosuppressants-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. If the patient has NOT tried at least TWO (2) medium or higher potency topical teroids, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Q9. Has the patient been advised that Elidel and tacrolimus should only be used to treat the immediate problem and then should be stopped when the condition improves?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tracleer-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 the patient's diagnosis for the requested medication:
☐ Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] group 1)
☐ Other

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

Q5. Does the patient have New York Heart Association (NYHA) Class II-IV symptoms?
☐ Yes ☐ No

Q6. Has the diagnosis of PAH been confirmed by right heart catheterization?
☐ Yes ☐ No

Q7. FOR FEMALE PATIENTS OF CHILD-BEARING POTENTIAL, will the patient use more than one method of contraception concurrently?
☐ Yes
☐ No
☐ N/A - Patient is not a female of child-bearing potential

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tracleer-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):

- ☐ AST/ALT level greater than 3 times the upper limit of normal (ULN)
- ☐ Patient is pregnant
- ☐ Concomitant use of cyclosporine A or glyburide
- ☐ None of the above

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
☐ Parental history of fracture
☐ Low body mass index (BMI)

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:**

- ☐ Current smoker
- ☐ Chronic alcohol use
- ☐ Rheumatoid arthritis
- ☐ 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:
Tysabri-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. What is the patient's diagnosis for the requested medication? *
☐ Multiple sclerosis (relapsing forms)
☐ Crohn's disease (moderate to severe)
☐ Other

Q4. For MULTIPLE SCLEROSIS, will Tysabri be used as monotherapy?
☐ Yes ☐ No

Q5. For CROHN'S DISEASE, will the medication be used in combination with immunosuppressants or inhibitors of tumor necrosis factor-alfa drugs?
☐ Yes ☐ No

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

Q7. Has the patient had an inadequate response, intolerance, or contraindication to any of the following?
☐ Avonex
☐ Betaseron

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Tysabri-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:**

- ☐ Cimzia
- ☐ Copaxone
- ☐ Extavia
- ☐ Gilenya
- ☐ Humira
- ☐ Rebif
- ☐ Remicade
- ☐ None of the above

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

☐ Yes ☐ No

Q9. Are the patient and physician registered in the TOUCH prescribing program?

☐ Yes ☐ No

Q10. Does the patient have a history of progressive multifocal leukoencephalopathy?

☐ Yes ☐ No

Q11. For CONTINUING THERAPY, has the patient had an objective response to therapy (for example, decreased flares)?

☐ 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 failed 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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Varizig-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:
☐ Passive immunization of varicella in high-risk patients
☐ Other

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

Q5. Will Varizig be given through the intramuscular (IM) route?
☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Varizig-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:
Venclexta-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: *
☐ Chronic lymphocytic leukemia (CLL)
☐ Other

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

Q5. Does the patient have 17p deletions (as detected by an approved test)?
☐ Yes ☐ No

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Venclexta-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:
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

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COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Verzenio-1 Medicare

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

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

Patient Name:	**Prescriber Name:**

☐ 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:
Vimpat-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. What is the patient's diagnosis for the requested medication?
☐ Partial-onset seizures
☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vimpat-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:
Vpriv-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:
☐ Gaucher disease ☐ Other

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

Q5. Has the diagnosis been confirmed by bone marrow histology, DNA testing, or measurement of beta-glucocerebrosidase enzyme activity of less than 30 percent?
☐ Yes ☐ No

Q6. Does the patient have at least one of the following conditions as a result of Type 1 Gaucher disease? (please select all that apply):
- ☐ Anemia
- ☐ Thrombocytopenia
- ☐ Bone disease
- ☐ Hepatomegaly
- ☐ Splenomegaly
- ☐ None of the above

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vpriv-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. For CONTINUING THERAPY (24 months or greater), has the patient experienced any of the following? (please select all that apply):

- ☐ A decrease in liver and spleen volume
- ☐ An increase in platelet count
- ☐ An increase in hemoglobin concentration
- ☐ None of the above

Q8. Will Vpriv be used in combination with miglustat (Zavesca)?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vyxeos-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:

☐ Therapy-related acute myeloid leukemia (t-AML)
☐ Acute myeloid leukemia with myelodysplasia-related changes (AML-MRC)
☐ Other

Q4. For a diagnosis of THERAPY-RELATED ACUTE MYELOID LEUKEMIA (t-AML), is the disease newly diagnosed?

☐ Yes ☐ No

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Vyxeos-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. Where does the patient reside?

- ☐ Home residence
- ☐ Long-term care (LTC) facility
- ☐ Other

Q9. If OTHER, please specify below:

Q10. Will the requested medication be administered via an infusion pump?

☐ Yes ☐ No

Q11. If the medication is being administered via an infusion pump, did Medicare pay for the pump?

☐ Yes ☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xenazine-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 (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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xenazine-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:
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:
Xifaxan-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. Which medication is this request for?
☐ Xifaxan 200 mg ☐ Xifaxan 550 mg

Q4. Please indicate the patient's diagnosis for the requested medication:
☐ Hepatic encephalopathy, prophylaxis
☐ Irritable bowel syndrome (IBS) with diarrhea
☐ Traveler's diarrhea, non-invasive strains of E. Coli
☐ Other

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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xifaxan-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:
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
☐ Persistent asthma (moderate to severe)
☐ 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 700 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 is intolerant to ICS or LABA OR member has a contraindication to ICS or LABA

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:**

☐ 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 ☐ 6-11 years ☐ 12 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:
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:
Yondelis-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:
☐ Soft tissue sarcoma, unresectable or metastatic (liposarcoma or leiomyosarcoma) in patients who have received a prior anthracycline-containing regimen
☐ Other

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

Q5. Is the requested medication being prescribed by an oncologist?
☐ Yes ☐ No

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

Q7. The following laboratory values must be included with this request. Have the following labs been included? (please select all that are attached):
☐ Absolute neutrophil count (ANC)
☐ Platelet count

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Yondelis-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:**

- ☐ Serum creatine phosphokinase
- ☐ Left ventricular ejection fraction
- ☐ None of the above

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. 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) ☐ Other

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

Q5. Is the medication to be used in combination with methylprednisolone?
☐ Yes ☐ No

Q6. Has the patient tried, or had an inadequate treatment response, adverse event, or contraindication to Zytiga?
☐ Yes ☐ No

Q7. If the patient has not tried Zytiga, is there a reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

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

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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
Q9. Is the medication prescribed by or in consultation with an oncologist or urologist?	
☐ Yes	☐ No

Prescriber Signature

Date

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zavesca-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 start date (MM/YY):

Q3. What is the patient's diagnosis for the requested medication?
☐ Diagnosis of mild to moderate type 1 Gaucher disease in patients who are not candidates for enzyme replacement therapy
☐ Other

Q4. If the diagnosis is OTHER, please specify:

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zavesca-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:
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

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

ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zorbtive-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:
☐ Short bowel syndrome ☐ 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):
☐ Active malignancy (newly diagnosed or recurrent)
☐ Acute critical illness due to complications following open heart or abdominal surgery
☐ Accidental trauma
☐ Acute respiratory failure
☐ None of the above

Q6. FOR CONTINUING THERAPY, has the patient shown a response to therapy (e.g., requirements for nutritional support have decreased or the patient's weight has stabilized or increased)?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zorbtive-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:
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) ☐ 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