

EOC ID:

Actimmune-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as writ	ten, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that nuestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	nerapy
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start da	ate (MM/YY):
Q3. Please indicate the patient's diagnosis for the reques	sted medication: *	
Chronic granulomatous disease for use in reducing the chronic granulomatous disease	ne frequency and seve	rity of serious infections associated with
☐ Severe malignant osteopetrosis (SMO) ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Prescriber Signature		Date



EOC ID:

Adempas-16 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Ot-t- I :- ID.
Group Number:	NPI:	State Lic ID:
Address: City, State ZIP:	Address:	
Primary Phone:	City, State ZIP: Specialty/facility name (if applicable	.)·
·		•
*Please note that Elixir will process the request as writte		O SUDSTITUTION.
- W 100 W	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		approval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
O2 Places indicate the nationals diagnosis for the request	ad madiantion: *	
Q3. Please indicate the patient's diagnosis for the requeste		
Chronic thromboembolic pulmonary hypertension (CTEPH) WHO Group 4		
☐ Pulmonary arterial hypertension (PAH) WHO Group☐ Other	1	
Other		
Q4. For CTEPH, please select if any of the following app	oly to this patient:	
☐ The patient has persistent or recurrent disease a	fter surgical treatment (such as p	ulmonary endarterectomy)
☐ The patient's condition is inoperable		
☐ None of the above		
Q5. For PAH, was the diagnosis confirmed by right hear	t catheterization?	
☐ Yes	□No	
Q6. If the patient's diagnosis is OTHER, please specify	below:	
Q7. For FEMALE patients, is the patient enrolled in the AD	EMPAS REMS program?	



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Patient Name:		Prescriber Name:
☐ Yes ☐ No ☐ N/A - the patient is not fem	ale	
Q8. Is the patient pregnant?		
☐ Yes	☐ No	☐ Not Applicable
that apply)? Nitrates or nitric oxide do	onors (such as amyl nitrate) bitors, including specific PDE	-5 inhibitors (such as sildenafil, tadalafil, or verdenafil) or
Q10. Does the patient have pu	Imonary hypertension assoc	iated with idiopathic interstitial pneumonia?
☐ Yes		□ No
Prescriber S	ignature	



EOC ID:

Alecensa-12 Medicare

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Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name	(if applicable):	
*Please note that Elixir will process the request as write	ten, including drug na	me, with no substitution.	
	☐ Expedited/Ur	gent	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.			
Od to this way west for initial an application the same of			
Q1. Is this request for initial or continuing therapy?	_		
☐ Initial therapy	☐ Continuing the	erapy	
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	ted medication: *		
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:		
Q5. Is the patient's disease anaplastic lymphoma kinase	(ALK)- positive?		
☐ Yes	□No		
Q6. Is the patient 18 years of age or older?			
☐Yes	□No		
Prescriber Signature		Date	



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Patient Name:	Prescriber Name:

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EOC ID:

Alpha-1 Proteinase Inhibitor-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, pleas	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency in adult patients with emphysema	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Does the patient have IgA deficiency?		
☐ Yes	□ No	
Q7. Is the medication prescribed by or in consultation with	a pulmonologist?	
☐ Yes	□ No	



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Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Alunbrig-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as written	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. For NSCLC, is the patient anaplastic lymphoma kin	ase (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 (Xalko	ri)?
☐ 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	



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Alunbrig-13 Medicare

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



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Ambrisentan-12 Medicare

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as writ	ten, including drug n	name, with no substitution.
	☐ Expedited/U	Jrgent
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or information following q	on for this patient that ruestions and sign.	may support approval. Please answer the
	· · · · · · · · · · · · · · · · · · ·	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	herapy
Q2. For continuing therapy, please specify start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Pulmonary arterial hypertension (PAH) WHO Grou	o I 🔲 Other	
Q4. If the diagnosis is OTHER, please specify.		
Q5. Was the diagnosis confirmed by right heart catheterizundergo a right heart catheterization (e.g., patient is frail,		ocardiogram if patient is unable to
☐Yes	□No	
O6 Please indicate if the natient has any of these exclus	ions:	
Q6. Please indicate if the patient has any of these exclus	ions:	
Q6. Please indicate if the patient has any of these exclus Pregnancy Idiopathic pulmonary fibrosis (IPF), including those		rtension



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Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Amphetamines-11 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / SIG.		
Please attach any pertinent medical history or information following que	for this patient that may support a	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate which medication is being requested:		
☐ Amphetamine-dextroamphetamine ER		
☐ Dextroamphetamine ER		
☐ Dextroamphetamine IR		
☐ Vyvanse		
Q4. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Attention Deficit Hyperactivity disorder (ADHD)		
□ Narcolepsy		
☐ Moderate to severe binge eating disorder		
☐ Other		
Q5. If the patient's diagnosis is OTHER, please specify	below:	
Q6. Please select all that apply:		
☐ Narcolepsy has been confirmed by a sleep study		



EOC ID:

Amphetamines-11 Medicare

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

Patient Name:	Prescriber Name:
The patient will not be concomitantly using the medical days of MAOI administration	tion confirming that a sleep study would not be feasible cation with MAOIs or will not use the medication within 14 cribing both MAOI and amphetamine/dextroamphetamine
Prescriber Signature	Date



EOC ID:

Arcalyst-12 Medicare

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility nam	e (if applicable):
*Please note that Elixir will process the request as writte	en, including drug r	name, with no substitution.
	☐ Expedited/L	Jrgent
Drug Name and Strength:	·	
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that restions and sign.	may support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	herapy
Q2. For CONTINUING THERAPY, please specify the sta	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Cryopyrin-associated periodic syndrome (CAPS),		
including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify to	pelow:	
Q5. Is the patient 12 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Arikayce-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	pplicable):
*Please note that Elixir will process the request as writt	en, including drug name	, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may s lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Pulmonary Mycobacterium avium complex (MAC) infection	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Will the requested medication be used as part of a co patients?	mbination antibacterial reg	imen in treatment of refractory
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication being prescribed by (or ir pulmonologist?	n consultation with) an infe	ctious disease specialist or
☐ Yes	☐ No	



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Arikayce-12 Medicare

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Patient Name:	Prescriber Name:	
Prescriber Signature		



EOC ID:

Auryxia-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	0.00.0 1.0.0.0
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the requ	uest as written, including drug nar	ne, with no substitution.
		ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that ma following questions and sign.	y support approval. Please answer the
	iononing quotiene una eigin	
Q1. Is this request for initial or continuing the	rapy?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please pro	ovide the start date (MM/YY):	
O2 Plagas indicate the nationals diagnosis for	r the requested medication:	
Q3. Please indicate the patient's diagnosis fo	<u> </u>	
☐ Hyperphosphatemia	☐ Other	
Q4. Does the patient have chronic kidney dis	ease (CKD)?	
☐ Yes	□No	
Q5. Is the patient on dialysis?		
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Does the patient have any iron overload	syndromes (e.g., hemochromatosis)	?
☐ Yes	☐ No	
Q8. Is the requested medication being prescr	ibed by, or in consultation with, a he	matologist or nephrologist?



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Patient Name:	Prescriber Name:	
☐ Yes	□No	
Prescriber Signatu	ure Date	



EOC ID:

Austedo-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	i for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, pleas	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chorea associated with Huntington's disease (Hunting	ton's chorea)	
☐ Tardive Dyskinesia		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Is the requested medication being prescribed by (or in	consultation with) a psychiatrist o	r neurologist?
☐ Yes	□ No	
	and all that analysis	
Q7. Does the patient have any of the following (please sele	ect all that apply)?	
☐ Hepatic impairment		
☐ Suicidal ideation		



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



EOC ID:

Ayvakit-14 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as wri	itten, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati	ion for this patient that n	nay support approval. Please answer the
	4	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Gastrointestinal stromal tumor, unresectable or	stea medication.	
metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	fy below:	
Q5. Is there presence of platelet-derived growth factor re D842V mutations?	eceptor alpha (PDGFRA	a) exon 18 mutation, including PDGFRA
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Ayvakit-14 Medicare

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



EOC ID:

Balversa-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	oproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Urothelial carcinoma, locally advanced or metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Is the requested medication prescribed by (or in consu	ultation with) an oncologist or urolo	gist?
☐ Yes	□ No	
Q7. Do any of the following apply to this patient (please se	lect all that apply)?	
☐ The patient has susceptible FGFR3 or FGFR2 gene	tic alterations	
☐ The patient has progressed during or following at lead including within 12 months of neoadjuvant or adjuvant plate. ☐ None of the above	·	ining chemotherapy,



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Patient Name:	Prescriber Name:	Prescriber Name:	
Prescriber Signature	Date		



EOC ID:

Bosentan-14 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applied	cable):
*Please note that Elixir will process the request as writte	en, including drug name, wi	ith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		port approval. Please answer the
tollowing que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, pleas	e provide the start date (MM/	YY):
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Pulmonary arterial hypertension (PAH)	Other	
Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
Q5. Has the diagnosis of PAH been confirmed by either of	the following?	
☐ Right heart catheterization	Ü	
☐ Doppler echocardiogram (if patient is unable to under	ergo a right heart catheterizat	ion [e.g., patient is frail, elderly,
etc.])	, g	<u> </u>
☐ None of the above		
Q6. Does the patient have World Health Organization (WH	(O) Group 1 and New York H	eart Association (NVHA)
Functional Class II-IV symptoms?	o) Gloup I and New Tolk III	eart Association (IVIIIA)
☐ Yes	□ No	
OZ FOR FEMALE RATIFAITO OF REPROPULITY (5 POT		a accelerate at a medical Conference Conference
Q7. FOR FEMALE PATIENTS OF REPRODUCTIVE POT	∟ιν ι ιAL, nas pregnancy beer	n excluded and patient will use



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Bosentan-14 Medicare

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

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

Patient Name:	Prescriber Name:
two forms of reliable contraception during therapy?	
☐ Yes	
□No	
☐ N/A - patient is not a female of reproductive potential	
Q8. Does the patient have aminotransferase elevations ac injury or bilirubin at least 2 times the upper limit of normal (. , , , , , , , , , , , , , , , , , , ,
☐ Yes	□ No
Q9. Will the patient be receiving concomitant cyclosporine	A or glyburide therapy?
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Bosulif-12 Medicare

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

Potiont Name:	Prescriber Name:	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support ap estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, pleas	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Philadelphia chromosome-positive (Ph+) chronic myelo	ogenous leukemia (CML)	
☐ Philadelphia chromosome-positive (Ph+) chronic myelo	• , ,	agnosed chronic phase)
☐ Other		
Q4. For Ph+ CML, has the patient had resistance, relaps following tyrosine kinase inhibitors (TKI) (please select a		therapy with one of the
☐ Gleevec (imatinib)		
Sprycel (dasatinib)		
☐ Tasigna (nilotinib)		
☐ None of the above		
		- the annual annual and the annual
Q5. If the patient has NOT tried any of the medicatio medications cannot be used (i.e. contraindication, his	·	
etc)?	story of davorce events, disease is t	oolotant or intolorant,
·		
Q6. If the patient's diagnosis is OTHER, please specify l	helow.	
Qo. II the patient's diagnosis is OTTILIX, piease specify i	OCIOVV.	



EOC ID:

Bosulif-12 Medicare

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

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



EOC ID:

Braftovi-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the re	quest as written, including drug nam	e, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	ry or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	nerapy?	
☐ Initial therapy	☐ Continuing then	ару
Q2. For CONTINUING THERAPY, please p	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Colorectal cancer (metastatic)		
☐ Melanoma (unresectable or metastatic) ☐ Other		
Q4. If the patient's diagnosis is OTHER, ple	ease specify below:	
Q5. Please select all that apply to the patie	nt:	
☐ The patient has a documented BRAF	V600E or V600K mutation as detected	by an FDA-approved test
☐ The patient has a documented BRAF V600E mutation as detected by an FDA-approved test		
The patient has received prior therap		
The requested medication will be used in combination with binimetinib (Mektovi)		
The requested medication will be used in combination with cetuximab		
☐ None of the above		
Q6. Is the patient 18 years of age or older?		



EOC ID:

Braftovi-12 Medicare

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Patient Name:	Prescriber Name:
☐ Yes	□No
Q7. Is the requested medication being prescribed by or in	consultation with an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Brukinsa-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as w	ritten, including drug na	nme, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	ation for this patient that m g questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	ne start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	ested medication:	
☐ Mantle cell lymphoma	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spe	cify below:	
Q5. Has the patient tried one prior therapy?		
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Brukinsa-13 Medicare

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

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Patient Name:	Prescriber Name:

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EOC ID:

Cablivi-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the request as writte	en, including drug nam	e, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing there	ару
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Thrombotic thrombocytopenic purpura, acquired (aTTP)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age and older?		
☐ Yes	□ No	
Q6. Will the requested medication be used in combination	with plasma exchange a	and immunosuppression therapy?
☐ Yes	□ No	
Q7. Please indicate the Prescriber's specialty:		
☐ Hematologist ☐ Oncologist		☐ None of the above



EOC ID:

Cablivi-13 Medicare

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Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Cabometyx-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, pleas	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Renal cell carcinoma (advanced)		
☐ Hepatocellular carcinoma (HCC) (advanced) in patient ☐ Other	s previously treated with Nexavar	(sorafenib)
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Does the patient have (or is at risk for) severe hemorrh	nage?	
☐ Yes	□ No	
Q7. Does the patient have a recent history of bleeding or h	emoptysis?	
☐ Yes	□ No	



EOC ID:

Cabometyx-12 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Calquence-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Diagon ette ele any montinent modicel bietem en information	for this potion t that many arranged a	annoval Diagon annovemble
Please attach any pertinent medical history or information following que	estions and sign.	oproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic lymphocytic leukemia		
☐ Mantle cell lymphoma		
☐ Small lymphocytic lymphoma		
☐ Other		
Q4. For MANTLE CELL LYMPHOMA, has the patient tri	ed one other therapy for MCL?	
☐ Yes	□No	
Q5. If the patient's diagnosis is OTHER, please specify	below:	
Q6. Is the requested medication prescribed by (or in consu	Itation with) an oncologist?	
☐ Yes	□No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	



EOC ID:

Calquence-13 Medicare

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Cayston-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the reques	st as written, including drug nam	e, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or fo	information for this patient that may blowing questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therap	py?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please inc	licate the start date (MM/YY):	
Q3. Please indicate that patient's diagnosis for t	he requested medication:	
☐ Cystic fibrosis (CF)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please	se specify below:	
Q5. Has the diagnosis been confirmed by appro	priate diagnostic or genetic testing	?
☐ Yes	☐ No	
Q6. Does the patient have evidence of P. aerug	inosa in the lungs as confirmed by	cultures of the airways?
☐ Yes	□ No	
Q7. Is the patient 7 years of age or older?		
Yes	□No	



EOC ID:

Cayston-12 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

CNS Stimulants-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	f applicable):
*Please note that Elixir will process the re	equest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	ry or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	nerapy?	
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING T	HERAPY, please provide the start date	(MM/YY):
Q3. Please indicate the patient's diagnosis	for the requested medication: *	
☐ Narcolepsy		
☐ Obstructive sleep apnea (OSA)		
Shift work disorder (SWD)		
☐ Other		
Q4. If the patient's diagnosis is OTHER,	please specify below:	
Q5. For NARCOLEPSY or OBSTRUCTIVE evaluation?	SLEEP APNEA (OSA), was the diagno	osis confirmed by sleep lab
☐ Yes	□No	
Prescriber Signature		Date



EOC ID:

CNS Stimulants-12 Medicare

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

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Patient Name:	Prescriber Name:
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EOC ID:

Copiktra-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support a	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic lymphocytic leukemia/small lymphocytic lymph	noma (CLL/SLL), relapsed or refra	ctory
☐ Follicular lymphoma, relapsed or refractory		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
an mana panama anagmasia ta anniin, piasaa apaam, t		
Q5. Has the patient been treated with at least 2 prior thera	pies?	
☐ Yes	□ No	
Q6. Is the requested medication being prescribed by (or in	consultation with) an oncologist o	r hematologist?
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	
		



EOC ID:

Copiktra-12 Medicare

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Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Corlanor-12 Medicare

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

Patient Name:	Prescriber Name:		
-			
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if	applicable):	
*Please note that Elixir will process the I	request as written, including drug nam	e, with no substitution.	
	☐ Expedited/Urge	nt	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	support approval. Please answer the	
Q1. Is this request for initial or continuing	therapy?		
☐ Initial therapy ☐ Continuing therapy			
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosi	s for the requested medication:		
Stable, symptomatic chronic heart t	ailure		
☐ Stable, symptomatic heart failure d	ue to dilated cardiomyopathy		
Q4. If the patient's diagnosis is OTHER	t, please specify below:		
Q5. For CHRONIC HEART FAILURE, doe	es the patient have any of the following (p	elease select all that apply)?	
☐ Left ventricular ejection fraction (LV	EF) 35% or less		
☐ Sinus rhythm with resting heart rate	•		
☐ Taking maximally tolerated doses of	•		
Contraindication to beta-blocker us			
☐ None of the above			
Q6. For HEART FAILURE DUE TO DILA	ΓΕD CARDIOMYOPATHY, is the patient	in sinus rhythm with an elevated	
heart rate?			



EOC ID:

Corlanor-12 Medicare

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Patient Name:	Prescriber Name:
☐ Yes	□No
Q7. Does the patient have any of the following (please select all that apply)? Bradycardia (i.e., resting heart rate is less than 60 beats per minute prior to treatment) Decompensated acute heart failure Hypotension (i.e., blood pressure less than 90/50 mmHg) Severe hepatic impairment (Child-Pugh C) Sick sinus syndrome, sinoatrial block, or 3rd degree AV block (unless a functioning demand pacemaker is present) None of the above	
Prescriber Signature	Date



EOC ID:

Cosentyx-12 Medicare

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

Patient Name:	P	rescriber Name:	
Member/Subscriber Number:	F	ax:	Phone:
Date of Birth:	С	Office Contact:	
Group Number:	N	IPI:	State Lic ID:
Address:	A	ddress:	
City, State ZIP:	C	City, State ZIP:	
Primary Phone:	S	specialty/facility name	e (if applicable):
*Please note that Elixir will	process the request as written,	including drug n	ame, with no substitution.
		☐ Expedited/U	Irgent
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinen	t medical history or information fo following quest		nay support approval. Please answer the
Q1. Is this request for initial	or continuing therapy?		
☐ Initial therapy		☐ Continuing to	herapy
Q2. For CONTINUING TH	HERAPY, please provide the start	date (MM/YY):	
Q3. Please indicate the patie	ent's diagnosis for the requested	medication:	
☐ Ankylosing spondylitis	3		
☐ Non-radiographic axia	al spondyloarthritis		
☐ Plaque psoriasis (mod	derate to severe)		
Psoriatic arthritis (acti	ve)		
Other			
Q4. If the patient's diagno	osis is OTHER, please specify bel	low:	
Q5. Has the patient tried and that apply)?	d failed (or has a contraindication	or intolerance) to	any of the following (please select all
☐ Enbrel	☐ Humira		☐ None of the above
-	T tried any of the medications listered (i.e., contraindication, history of	· ·	question, is there a reason why these etc.)?



EOC ID:

Cosentyx-12 Medicare

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Patient Name:	Prescriber Na	me:
Q7. Has the patient been scree	ned for latent tuberculosis infection as req	uired prior to initiation of treatment?
☐ Yes	☐ No	
Q8. Is the requested medication	n prescribed by (or in consultation with) an	y of the following?
☐ Dermatologist	Rheumatologist	☐ None of the above
Prescriber Si	gnature	Date



EOC ID:

Cotellic-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as writt	ten, including drug n	ame, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	n for this patient that nuestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. For CONTINUING THERAPY, please indicate the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ted medication:	
☐ Melanoma (unresectable or metastatic malignant)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have BRAF V600E or V600K mutation	on?	
☐ Yes	☐ No	
Q6. Will the requested medication be used in combination	with vemurafenib (Ze	elboraf)?
☐ Yes	□No	
Prescriber Signature		Date



EOC ID:

Cotellic-12 Medicare

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Patient Name:	Prescriber Name:

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EOC ID:

Cystaran-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	e):
*Please note that Elixir will process the request as writt	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
	<u></u>	
Cystinosis	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have corneal crystal accumulation?		
☐ Yes	□ No	
Q6. Does the patient have any hypersensitivity to cysteam	ine or penicillamine?	
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Cystaran-13 Medicare

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

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Patient Name:	Prescriber Name:

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EOC ID:

Dalfampridine-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	ifor this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please specify the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication: *	
☐ Multiple sclerosis (MS)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Has patient demonstrated sustained walking impairme assistance) prior to starting the medication?	nt, but with the ability to walk 25 fe	eet (with or without
☐ 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 sele	ect all that apply)?	



EOC ID:

Dalfampridine-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ History of seizure ☐ Moderate or severe renal impairment (creatinine cle. ☐ None of the above	arance less than or equal to 50 mL/minute)
Prescriber Signature	Date



EOC ID:

Daurismo-12 Medicare

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

	T.	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	e):
*Please note that Elixir will process the request as written	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Acute myeloid leukemia (newly diagnosed)	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have comorbidities that preclude the	use of intensive induction chemo	therapy?
☐ Yes	□No	
Q6. Will Daurismo be used in combination with cytarabine	?	
☐ Yes	□ No	
Q7. Is the patient 75 years of age or older?		
☐ Yes	□ No	
Q8. Is the medication being prescribed by (or in consultation	on with) an oncologist or hematok	ogist?
☐ Yes	□ No	



EOC ID:

Daurismo-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Deferasirox-11 Medicare

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

Patient Name:	Prescriber Name:	
		Dhanai
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
Group Number:	NPI:	State Lic ID:
Address:	Address:	otato Elo ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or information following que	for this patient that may support a	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTNUING THERAPY, please specify the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic iron overload due to blood transfusions (tran		
☐ Chronic iron overload in non-transfusion-dependent thalassemia syndromes		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. For CHRONIC IRON OVERLOAD DUE TO BLOOD T	RANSFUSIONS, please select all	that apply to the patient:
☐ The patient had a transfusion of at least 100 mL/kg ¡	packed red blood cells	
☐ The patient has serum ferritin level greater than 100☐ None of the above	0 mcg/L	
Q6. For CHRONIC IRON OVERLOAD IN NON-TRANSFU select all that apply to the patient:	SION-DEPENDENT THALASSEM	MIA SYNDROMES, please
☐ Patient has liver iron concentrations of at least 5 mg ☐ Patient has serum ferritin level greater than 300 mcg	• • •	



EOC ID:

Deferasirox-11 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 exclusions?	(Please select all that apply to the patient)
☐ Advanced malignancy	
☐ Creatinine clearance less than 40 mL/min	
☐ High risk myelodysplastic syndrome (MDS)	
☐ Platelet count less than 50 x 10(9)/L	
☐ Poor performance status	
☐ None of the above	
Prescriber Signature	Date



EOC ID:

Diclofenac Topical-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the re	quest as written, including drug nan	e, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing the	nerapy?	
☐ Initial therapy	☐ Continuing ther	ару
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



EOC ID:

Dronabinol-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Elixir will process the re	equest as written, including drug name	e, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing t	herany?	
☐ Initial therapy	Continuing thera	ру
Q2. For CONTINUING THERAPY, please	se specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s for the requested medication: *	
☐ Anorexia associated with weight loss in	n a patient with AIDS	
☐ Chemotherapy-induced nausea and vo	•	
☐ Other		
Q4. If the patient's diagnosis is OTHER,	, please specify below:	
Prescriber Signature		Date



EOC ID:

Enbrel-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support a	pproval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
	Continuing thereny	
☐ Initial therapy	Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Ankylosing spondylitis		
☐ Chronic plague psoriasis, moderate to severe		
☐ Chronic plaque psoriasis, moderate to severe ☐ Polyarticular juvenile idiopathic arthritis, moderate to severe		
Psoriatic arthritis		
☐ Rheumatoid arthritis, moderate to severe		
☐ Other		
	h ala	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For PLAQUE PSORIASIS, is the patient a candidate for systemic therapy or phototherapy?		
☐ Yes	□ No	
Q6. Has the patient been screened for latent tuberculosis i	nfection prior to initiation of treatm	ent?
☐ Yes	□ No	



EOC ID:

Enbrel-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Endari-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as written	n, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this natient that may support a	nnroval Please answer the
	stions and sign.	pprovail ricuse answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requester	d medication:	
☐ Acute complications associated with sickle cell diseas	e	
Q4. If the patient's diagnosis is OTHER, please specify b	elow:	
Q5. Is the patient 5 years of age or older?		
☐ Yes	□ No	
Prescriber Signature		Date



EOC ID:

Entresto-14 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Otata Lia ID.
Group Number:	NPI:	State Lic ID:
Address: City, State ZIP:	Address:	
Primary Phone:	City, State ZIP: Specialty/facility name (if	applicable):
·		
*Please note that Elixir will process the request as writte	en, including drug nam	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or information	n for this patient that may	support approval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
Q3. Please indicate the patient's diagnosis for the request	od modication:	
	eu medication.	
Chronic heart failure		
☐ Symptomatic heart failure☐ Other		
Q4. For CHRONIC HEART FAILURE, please select all	that apply to this patient:	:
☐ The patient has New York Heart Association (N)	YHA) class II to IV heart	failure
☐ The patient has reduced ejection fraction (left ve	ntricular ejection fraction	n less than or equal to 40%)
☐ None of the above		
Q5. For SYMPTOMATIC HEART FAILURE, does the page 1	atient have systemic left	ventricular systolic dysfunction?
Yes	□ No	
Q6. If the patient's diagnosis is OTHER, please specify	below:	
Q7. Does the patient have any of the following EXCLUSIC	NS (please select all that	at apply)?



EOC ID:

Entresto-14 Medicare

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

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

Patient Name:	Prescriber Name:
☐ History of angioedema related to previous ACE-inhit ☐ Concomitant use, or use within 36 hours of an ACE-☐ Concomitant use with aliskiren in a diabetic patient ☐ None of the above	
Prescriber Signature	Date



EOC ID:

Epidiolex-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Elixir will process the r	request as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, plea	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s for the requested medication:	
Severe myoclonic epilepsy in infancy	•	
Lennox-Gastaut syndrome (LGS)	(Diavet dynatome)	
☐ Other		
Q4. Is the patient 2 years of age or olde	er?	
☐ Yes	□No	
Q5. If the patient's diagnosis is OTHER	, please specify below:	
Q6. Is the requested medication being pre	escribed by (or in consultation with) a ne	urologist?
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Epidiolex-12 Medicare

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

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

Patient Name:	Prescriber Name:



EOC ID:

Erleada-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the request as writt	en, including drug nam	e, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may lestions and sign.	support approval. Please answer the
.o.io.iiiig qa		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Non-metastatic castration-resistant prostate cancer		
☐ Metastatic, castration-sensitive prostate cancer		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow:	
Q II the patient e diagnosis to G TTET, piedes opening	bolow.	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q6. Is the requested medication prescribed by (or in const	ultation with) an oncologi	st or urologist?
☐ Yes	☐ No	
Q7. Is the patient's partner pregnant?		
☐ Yes ☐ No		□ N/A



EOC ID:

Erleada-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Esbriet-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request a	s written, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or info follow	rmation for this patient that ma ving questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please specif	y the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the r	equested medication:	
☐ Idiopathic pulmonary fibrosis (IPF)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please s	specify below:	
Q5. Is the prescriber a pulmonologist?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

ESRD Therapy-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	<i>x</i>):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	i for this patient that may support a estions and sign.	ipproval. Please answer the
	-	
Q1. Is this request for initial therapy or continuing therapy?	*	
│	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please specify the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication: *	
☐ Anemia associated with chronic kidney disease (CKD)		
☐ Anemia associated with myelosuppressive chemother	ару	
☐ Anemia associated with zidovudine therapy in a patient with HIV infection		
☐ Reduction of blood transfusions in a patient undergoing elective, non-cardiac, non-vascular surgery		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow:	
44. If the patient's diagnosis is 3 TTER, piedoe spesify	Sciow.	
2-1-11-11-11-11-11-11-11-11-11-11-11-11-	40 / 11 0	
Q5. Is the patient's pre-treatment hemoglobin level less the	an 10 g/dL?	
☐ Yes	□ No	
Q6. Will there be a dose reduction or interruption if the her	moglobin level exceeds one of the	following: 10 g/dL (adult
CKD not on dialysis, or cancer); 11 g/dL (CKD on dialysis)	_	
☐ Yes	□ No	



EOC ID:

ESRD Therapy-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Farydak-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the requ	iest as written, including drug name	e, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history of	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing ther	rapy?	
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	r the requested medication:	
☐ Multiple myeloma	☐ Other	
Q4. If the patient's diagnosis is OTHER, ple	ease 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 dexametha	asone?
☐ Yes	☐ No	
Q7. Has the patient received at least two (2) pagent [eg, Revlimid (lenalidomide), Thalomid		Velcade) and an immunomodulatory
☐ Yes	☐ No	
Q8. Is the requested medication being prescri	ibed by (or in consultation with) an one	cologist or hematologist?



EOC ID:

Farydak-12 Medicare

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

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



EOC ID:

Fasenra-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as	written, including drug na	ame, with no substitution.
	☐ Expedited/Ui	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform following	nation for this patient that m ng questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the red	quested medication:	
☐ Severe asthma with an eosinophilic phenotype	☐ Other	
Q4. If the patient's diagnosis is OTHER, please sp	ecify below:	
Prescriber Signature		Date



EOC ID:

Fentanyl Oral-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	licable):
*Please note that Elixir will process the request as writ	ten, including drug name, v	vith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following quantum followi	on for this patient that may sup	pport approval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please specify the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Cancer-related breakthrough pain	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient currently receiving and tolerant to arour	nd-the-clock opioid therapy fo	r persistent cancer pain?
☐ Yes	☐ No	
Q6. Are the patient and prescriber registered in the Trans Mitigation Strategy Access Program?	mucosal Immediate Release	Fentanyl (TIRF) Risk Evaluation
☐ Yes	☐ No	
Q7. Will the medication be used for management of acute pain, or use in the emergency room?	e or post-operative pain, inclu	ding headache/migraine, dental
☐ Yes	□ No	



EOC ID:

Fentanyl Oral-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 opioid tolerant? Patients are considered or longer (for example, at least 60 mg of oral morphine or	d opioid tolerant when taking another opioid daily for a week an equianalgesic dose of another opioid).
☐ Yes ☐ No	
Prescriber Signature	Date



EOC ID:

Firdapse-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as wri	tten, including drug na	nme, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati following of	on for this patient that m questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Lambert-Eaton myasthenic syndrome (LEMS)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Does the patient have a history of seizures?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Firdapse-12 Medicare

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

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

Patient Name:	Prescriber Name:

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EOC ID:

Galafold-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as wr	ritten, including drug na	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informat following	tion for this patient that m questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Fabry disease	☐ Other	
Q4. If the patient's diagnosis is OTHER, please speci	ify below:	
Q5. Does the patient have an amenable galactosidase a	alpha gene (GLA) mutati	on?
☐ Yes	☐ No	
Q6. Is the patient 16 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Galafold-12 Medicare

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

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

Patient Name:	Prescriber Name:



EOC ID:

Gilotrif-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)) :
*Please note that Elixir will process the request as writte	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		pproval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Non–small cell lung cancer (NSCLC), metastatic		
☐ Non-small cell lung cancer (NSCLC), metastatic squ ☐ Other	amous (previously treated)	
Q4. Has the patient's disease progressed following plati	num-based chemotherapy?	
☐ Yes	□ No	
Q5. If the patient's diagnosis is OTHER, please specify	below:	
Q6. Do the patient's tumors have non-resistant epidermal of FDA-approved test?	growth factor receptor (EGFR) mu	tations as detected by an
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	



EOC ID:

Gilotrif-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Q8. Is the requested medication being prescribed by (or in	consultation with) an oncologist?	
☐ Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Gocovri-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact: NPI:	State Lic ID:
Group Number: Address:	Address:	State Lic ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	١٠
		•
*Please note that Elixir will process the request as writte		O SUDSTITUTION.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		pproval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Extrapyramidal disease	ou modication.	
Parkinson's disease		
Other		
_		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For PARKINSON'S DISEASE, please select all that ap	oply to this patient:	
☐ Patient is experiencing dyskinesia		
☐ Patient is receiving levodopa-based therapy		
☐ None of the above		
Q6. Has the patient tried and failed amantadine immediate	release?	
Yes	□ No	
Q7. Does the patient have end stage renal disease (ESRD	, CrCl below 15 mL/min/m^2)?	



EOC ID:

Gocovri-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Yes	□No
Q8. Is the requested medication prescribed by, or in cons	ultation with, a neurologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Growth Hormone-13 Medicare

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

Member/Subscriber Number: Date of Birth: Group Number: Address: Fax: Phone: Office Contact: NPI: State Lic ID: Address:			
Date of Birth: Group Number: Office Contact: NPI: State Lic ID:			
Address: Address:			
City, State ZIP: City, State ZIP:			
Primary Phone: Specialty/facility name (if applicable):			
*Please note that Elixir will process the request as written, including drug name, with no substitution.			
□ Expedited/Urgent			
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information for this patient that may support approval. Please answer following questions and sign.	the		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy ☐ Continuing therapy			
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requested medication:			
☐ Chronic renal insufficiency (CRI)			
Growth hormone deficiency (GHD), adult Short-stature homeobox-containing gene (SHOX)			
Growth hormone deficiency (GHD) nediatric			
☐ Small for gestational age (SGA) ☐ Idiopathic short stature			
☐ Noonan syndrome ☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. For CHRONIC RENAL INSUFFICIENCY, please select all that apply to the patient:			
☐ Nutritional status has been optimized			
☐ Metabolic abnormalities have been corrected			
☐ Patient has not had renal transplant			
☐ None of the above			



EOC ID:

Growth Hormone-13 Medicare

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

Patient Name:	Prescriber Name:		
Q6. For PEDIATRIC GROWTH HORMONE DEFICIENCY, please select all that apply to the patient: The patient's bone age is at least 1 year or 2 standard deviations (SD) delayed compared with chronological age The patient had 2 stimulation tests with peak growth hormone (GH) secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SD below mean if there is central nervous system (CNS) pathology, history of irradiation, or proven genetic cause None of the above			
Q7. For PRADER-WILLI SYNDROME, has the diagnosis b	een confirmed by genetic testing?		
Q8. For SMALL FOR GESTATIONAL AGE, please select all that apply to the patient: The patient's birth weight or length is 2 or more standard deviations (SD) below mean for gestational age The patient failed to manifest catch up growth by age 2 (height 2 or more SD below mean for age and gender) None of the above			
Q9. For TURNER SYNDROME, has the diagnosis been co	onfirmed by chromosome analysis?		
Q10. For PEDIATRIC GROWTH HORMONE DEFICIENCY, CHRONIC RENAL INSUFFICIENCY, SHOX DEFICIENCY, NOONAN SYNDROME, OR PRADER-WILLI SYNDROME, please select all that apply to the patient: The patient's height is more than 3 standard deviations (SD) below mean for age and gender The patient's height is more than 2 SD below mean with growth velocity (GV) more than 1 SD below mean The patient's GV over 1 year is 2 SD below mean None of the above			
Q11. For ADULT GROWTH HORMONE DEFICIENCY (GROWTH HORMONE DEFICIENCY (GROWTH HORMONE DEFICIENCY (GROWTH HORMONE GHD) confirmed by 2 standard growth hormone (GH) stimulation tests The patient had an insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L) Insulin tolerance tests are contraindicated, and the patient had a standardized stimulation test (such as arginine plus GH releasing hormone, glucagon, arginine) The patient has at least 1 other pituitary hormone deficiency and failed at least 1 GH stimulation test The patient has panhypopituitarism (3 or more pituitary hormone deficiencies) The patient has irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region	HD), please select all that apply to the patient: The patient has a subnormal IGF-1 (after at least 1 month off GH therapy) The patient has objective evidence of GHD complications, such as low bone density, increased visceral fat mass, or cardiovascular complications The patient has completed linear growth (growth velocity [GV] less than 2 cm/year) Growth hormone has been discontinued for at least 1 month (if previously receiving GH) None of the above		



EOC ID:

Growth Hormone-13 Medicare

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

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

Patient Name:	Prescriber Name:		
Q12. For ADULT GROWTH HORMONE DEFICIENCY, please provide the growth hormone (GH) stimulation tests that the patient underwent below.			
Q13. Does the patient have any of the following (please se	elect all that apply)?		
☐ The medication will be used for growth promotion in pediatric patients with closed epiphyses			
☐ Acute critical illness caused by complications following open-heart or abdominal surgery, multiple accidental			
trauma, or acute respiratory failure			
Active malignancy			
 ☐ Active proliferative or severe non-proliferative diabet ☐ None of the above 	tic retinopatny		
Prescriber Signature	Date		



EOC ID:

Hepatitis C-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable)):	
*Please note that Elixir will process the request as writte	en, including drug name, with no	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following que	for this patient that may support a	pproval. Please answer the	
	-		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Chronic Hepatitis C	☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Please provide the patient's genotype, subtype and que therapy:	antitative HCV RNA (viral load) te	sting any time prior to	
Q6. Has the prescriber documented the following within 12 panel, and GFR?	weeks of initiating therapy: CBC,	INR, hepatic function	
☐ Yes	□ No		
Q7. Is the patient post-transplant?			
☐ Yes	□ No		
	· 		



EOC ID:

Hepatitis C-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. What is the patient's cirrhosis status?	
Q9. What is the patient's prior treatment history (if any)?	
Q10. What is the patient's planned duration of treatment?	
Q11. Is the requested medication prescribed by, or in consapply)?	cultation with, one of the following (please select any that
☐ Gastroenterologist ☐ Hepatologist	
☐ Infectious Disease Specialist	
☐ None of the above	
Q12. For Vosevi: Has the patient had trial and failure, cont (Epclusa)?	raindication, or intolerance to velpatasvir/sofosbuvir
☐ Yes	□ No
Q13. If the patient has NOT tried the medication listed in cannot be used (i.e., contraindication, history of adverse	the previous question, is there a reason why this medication event, etc.)?
Prescriber Signature	 Date



EOC ID:

Hetlioz-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name	(if applicable):	
*Please note that Elixir will process the request as wi	ritten, including drug na	ame, with no substitution.	
	☐ Expedited/U	rgent	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information	tion for this patient that m questions and sign.	nay support approval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing the	nerapy	
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the reque	ested 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		
Prescriber Signature		Date	



EOC ID:

Hetlioz-12 Medicare

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

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Patient Name:	Prescriber Name:

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EOC ID:

HRM Muscle Relaxants-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as v	vritten, including drug na	nme, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform followin	ation for this patient that m g questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erany
		етару
Q2. For CONTINUING THERAPY, please provide t	he start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	uested medication:	
☐ Acute painful musculoskeletal conditions	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Is the patient 65 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Humira-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable)	:	
*Please note that Elixir will process the request as writte	n, including drug name, with no	substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following que	for this patient that may support a stions and sign.	oproval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	d medication:		
☐ Ankylosing spondylitis	☐ Polyarticular juvenile idiopa	thic arthritis, moderate to	
☐ Crohn's disease, moderate to severe	severe		
☐ Hidradenitis suppurativa, moderate to severe	☐ Psoriatic arthritis		
☐ Non-infectious uveitis (including intermediate, posterior	·		
and panuveitis)	Ulcerative colitis, moderate	to severe	
☐ Plaque psoriasis, moderate to severe chronic	Other		
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. For CROHN'S DISEASE, has the patient had an inadequate response to conventional therapy?			
☐ Yes	□ No		
Q6. For PLAQUE PSORIASIS, is the patient a candidate for systemic therapy or phototherapy, and are other systemic therapies medically less appropriate?			
☐ Yes	□ No		



EOC ID:

Humira-12 Medicare

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

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Patient Name:	Prescriber Name:	
Q7. For ULCERATIVE COLITIS, has the patient had an inacorticosteroids, azathioprine)?	adequate response to immunosuppressants (e.g.,	
☐ Yes	□ No	
Q8. Has the patient been screened for latent tuberculosis infection before initiation of treatment?		
☐ Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Ibrance-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if	applicable):	
*Please note that Elixir will process the request as write	ten, including drug nam	e, with no substitution.	
	☐ Expedited/Urge	nt	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or informatio following qu	n for this patient that may uestions and sign.	support approval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing thera	ару	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the request	ted medication:		
☐ Breast cancer, advanced or metastatic	☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?			
Yes	□ No		
Q6. Please indicate how the requested medication will be	used:		
 ☐ In combination with an aromatase inhibitor ☐ In combination with fulvestrant (Faslodex) after disc ☐ None of the above 	ease progression following	g endocrine therapy	
Q7. Please select which of the following applies to the particular to the particular than the patient is a man	tient:		



EOC ID:

Ibrance-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 is a postmenopausal woman☐ None of the above	
Q8. Is the patient 18 years of age or older?	
☐Yes	□ No
Q9. Is the medication prescribed by or in consultation with	an oncologist?
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Iclusig-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic myeloid leukemia (CML), chronic, accelerated		
☐ Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL)		
☐ Other	o round (r rr - r.E.E.)	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient T315I-positive?		
☐ Yes	□ No	
Q6. Is no other tyrosine kinase inhibitor therapy indicated f	or the patient?	
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	



EOC ID:

Iclusig-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Q8. Is the requested medication prescribed by or in consultation with an oncologist or hematologist?		
☐ Yes ☐ No		
Prescriber Signature	Date	



EOC ID:

Idhifa-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Elixir will process the request as writt	en, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that ma	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
	ed medication:	
Q3. Please indicate the patient's diagnosis for the request	☐ Other	
Q3. Please indicate the patient's diagnosis for the request Acute myeloid leukemia (AML), relapsed/refractory	Other	d by an FDA approved test?
Q3. Please indicate the patient's diagnosis for the request Acute myeloid leukemia (AML), relapsed/refractory Q4. If the patient's diagnosis is OTHER, please specify	Other	d by an FDA approved test?
Q3. Please indicate the patient's diagnosis for the request Acute myeloid leukemia (AML), relapsed/refractory Q4. If the patient's diagnosis is OTHER, please specify Q5. Does the patient have an an isocitrate dehydrogenase	Other below: 2 mutation as detecte	d by an FDA approved test?
Q3. Please indicate the patient's diagnosis for the request Acute myeloid leukemia (AML), relapsed/refractory Q4. If the patient's diagnosis is OTHER, please specify Q5. Does the patient have an an isocitrate dehydrogenase	Other below: 2 mutation as detecte	d by an FDA approved test?
Q3. Please indicate the patient's diagnosis for the request Acute myeloid leukemia (AML), relapsed/refractory Q4. If the patient's diagnosis is OTHER, please specify Q5. Does the patient have an an isocitrate dehydrogenase Yes Q6. Is the patient 18 years of age or older?	Other below: 2 mutation as detecte No	



EOC ID:

Idhifa-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Imbruvica-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic lymphocytic leukemia (CLL), with or without 17		
☐ Mantle cell lymphoma (MCL)		
☐ Marginal zone lymphoma (relapsed/refractory)		
☐ Small lymphocytic lymphoma (SLL), with or without 17p deletion		
☐ Waldenstrom's macroglobulinemia (WM)		
Graft-versus-host disease		
☐ Other		
Q4. For MANTLE CELL LYMPHOMA, has the patient re	caived at least one (1) prior thera	2
	<u></u>	уу :
☐ Yes	□ No	
Q5. For MARGINAL ZONE LYMPHOMA, please select	all that apply:	
☐ Patient requires systemic therapy		
☐ Patient has received at least one (1) prior anti-CD20-based therapy		
☐ None of the above		



EOC ID:

Imbruvica-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Q6. If the patient's diagnosis is OTHER, please specify below:		
Q7. FOR GRAFT-VERSUS-HOST disease, has the patien	t failed at least one first-line corticosteroid therapy?	
☐ Yes	□ No	
Q8. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Prescriber Signature	Date	



EOC ID:

Inbrija-12 Medicare

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

Potiont Name:	Prescriber Name:		
Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable	e):	
*Please note that Elixir will process the request as written	en, including drug name, with i	no substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information	n for this patient that may support estions and sign.	approval. Please answer the	
3.1	.		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the request	ed medication:		
☐ Parkinson's disease	☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Will the requested medication be used concurrently w	ith carbidopa/levodopa?		
☐ Yes	☐ No		
Q6. Has the patient tried and failed or has a contraindication	on to one generic formulary alterr	native?	
☐ Yes	□ No		
Q7. If the patient has NOT tried one generic formulary a contraindication, history of adverse event, etc.)?	lternative, is there a reason why	it cannot be used (i.e.,	
Q8. Is the patient 18 years old or older?			



EOC ID:

Inbrija-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Yes	□ No
Q9. Do any of the following apply to this patient? (Please s Concurrent use with nonselective monoamine oxidas Recent use (within 2 weeks) with a nonselective MA None of the above	se inhibitor (MAOI) (e.g., phenelzine or tranylcypromine)
Prescriber Signature	Date



EOC ID:

Increlex-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the re	equest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ry or information for this patient that may following questions and sign.	support approval. Please answer the
	Tonorming quocations and origin	
Q1. Is the request for initial or continuing the	nerapy?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Growth failure in a child with severe primary insulin-like growth factor 1 (IGF-1) deficiency		
Growth hormone (GH) gene deletion Other	n in a child who has developed neutraliz	ing antibodies to GH
Q4. If the patient's diagnosis is OTHER	please specify below:	
Q5. Please select any of the following that	applies to the patient:	
☐ The patient has active or suspected	malignancy	
☐ The medication will be used for grow	vth promotion in a patient with closed ep	piphyses
☐ The medication will be administered	intravenously	
☐ None of the above		
Prescriber Signature		Date



EOC ID:

Increlex-12 Medicare

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

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

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



EOC ID:

Inrebic-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writ	ten, including drug na	nme, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Places attach any portinent modical history or informatic	on for this nations that m	ay august approval. Places appwer the
Please attach any pertinent medical history or information following q	uestions and sign.	ay support approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
	Continuing th	orany
☐ Initial therapy	☐ Continuing th	егару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Myelofibrosis (MF), intermediate-2 or high-risk prim	ary	
or secondary (post-polycythemia vera or post-essential thrombocythemia)	☐ Other	
· ·	, le al avvi	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Is the patient 18 years of age or older?		
Yes	☐ No	
	INO	
Q6. Is the requested medication prescribed by, or in cons	sultation, with an oncolo	gist or hematologist?
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Inrebic-12 Medicare

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

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

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



EOC ID:

Intrarosa-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Elixir will process the reque	st as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or	information for this patient that ma ollowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing thera	 py?	
☐ Initial therapy	☐ Continuing the	егару
Q2. For CONTINUING THERAPY, please pr	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for t	he requested medication:	
☐ Moderate to severe dyspareunia due to me	nopause	
☐ Atrophic vaginitis due to menopause		
☐ Other		
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Does the patient have any of the following	(please select all that apply)?	
☐ Known or suspected estrogen-dependen	t neoplasia	
☐ Vaginal bleeding or dysfunctional uterine	bleeding of an undetermined orig	in



EOC ID:

Intrarosa-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Iressa-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as	s written, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information follows	rmation for this patient that maring questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide	e the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the re	equested medication:	
☐ Non-small cell lung cancer, metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please s	pecify below:	
Q5. Does the patient have known active epidermal (L858R) substitution mutations as detected by a FD approved facility?		
☐ Yes	□ No	
Prescriber Signature		Date



EOC ID:

Isturisa-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicate	ole):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may suppor estions and sign.	t approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Cushing's disease	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Please select if any of the following apply to this patien	nt:	
☐ Pituitary surgery has not been curative for this patie	nt	
☐ Pituitary surgery is not an option for this patient		
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
	المانية والمستعمل والمناب والمالية	<u> </u>
Q7. Is the requested medication prescribed by (or in consu		(
Yes	□ No	



EOC ID:

Isturisa-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Itraconazole-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Elixir will process the reques	st as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or fo	information for this patient that may illowing questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therap	y?	
☐ Initial therapy	☐ Continuing ther	тару
Q2. For CONTINUING THERAPY, please pro	ovide the start date (MM/YY):	
Q3. Please indicate the drug that is being reque	sted:	
☐ Itraconazole capsules		
☐ Itraconazole solution		
Other		
Q4. If OTHER, please list the medication:		
Q5. Please indicate the patient's diagnosis for the	ne requested medication: *	
☐ Candidiasis (esophageal or oropharyngeal)		
Onychomycosis		
Systemic fungal infection (e.g., aspergillosis	, histoplasmosis, blastomycosis)	
☐ Pulmonary histoplasmosis		
☐ Other		
Q6. If the patient's diagnosis is OTHER, pleas	se specify below:	
	· •	



EOC ID:

Itraconazole-13 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 CANDIDIASIS, is the disease refractory to treatme	ent with fluconazole?	
☐Yes	□ No	
Q8. For ONYCHOMYCOSIS, was the diagnosis confirmed by one of the following: a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy?		
Yes	□ No	
Q9. Does the patient have any of the following (please select all that apply)?		
☐ Ventricular dysfunction (e.g., congestive heart failure [CHF] or history of CHF)		
☐ Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.)		
☐ None of the above		
Prescriber Signature	Date	



EOC ID:

IVIG-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	plicable):
*Please note that Elixir will process the request as writte	en, including drug name, t	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may su estions and sign.	pport approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	,
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic inflammatory demyelinating polyneuropathy (0	CIDP)	
☐ Idiopathic or chronic immune thrombocytopenic purpur	ra	
☐ Motor neuropathy with multiple conduction block		
☐ Prevention of bacterial infection in patients with hypogammaglobulinemia or recurrent bacterial infections with B-cell chronic lymphocytic leukemia (CLL)		
☐ Prevention of coronary artery aneurysms associated with Kawasaki syndrome		
☐ Primary humoral immunodeficiency (congenital agammaglobulinemia, severe combined immunodeficiency syndromes [SCIDS], common variable immunodeficiency, X-linked immunodeficiency, Wiskott-Aldrich syndrome) ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Does the patient have any of the following (please sele	ect all that apply)?	
☐ Acute corn or maltose hypersensitivity		
☐ Hereditary fructose intolerance		



EOC ID:

IVIG-13 Medicare

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Patient Name:	Prescriber Name:
☐ Hyperprolinemia ☐ IgA deficiency with antibody formation and a history ☐ History of anaphylaxis or severe systemic reaction to ☐ None of the above	
Prescriber Signature	 Date



EOC ID:

Juxtapid-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	e):
*Please note that Elixir will process the request as writt	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may support a	approval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Homozygous familial hypercholesterolemia ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Has the diagnosis of homozygous familial hypercholes select all that apply)?	sterolemia been confirmed by any	of the following (please
☐ Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (LDLRAP1 or ARH)		
☐ The patient has untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL ☐ Xanthoma before 10 years of age		
Evidence of heterozygous familial hypercholesterole	emia in both parents	
☐ None of the above		
Q6. Please select any of the following that apply to the par	tient:	
☐ The patient is pregnant		



EOC ID:

Juxtapid-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 moderate or severe liver impairment abnormal liver function tests ☐ The requested medication will be used concomitant! ☐ None of the above 	t, or active liver disease including unexplained persistent y with strong or moderate CYP 3A4 inhibitors
Q7. Is the patient 18 years of age or older?	
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Kalydeco-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Elixir will process the	request as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical hist	ory or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosi	is for the requested medication:	
☐ Cystic fibrosis	☐ Other	
Q4. If the patient's diagnosis is OTHEF	R, please specify below:	
Q5. Does the patient have a cystic fibrosi responsive to ivacaftor potentiation based		(CFTR) gene mutation that is
☐ Yes	□ No	
Prescriber Signature		Date



EOC ID:

Kisqali-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate which medication this request is for:		
☐ Kisqali	☐ Kisqali Femara	
Q4. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Breast cancer, advanced or metastatic	☐ Other	
Q5. If the patient's diagnosis is OTHER, please specify	below:	
Q6. Is the patient's disease hormone receptor (HR)-positive negative?	e, human epidermal growth factor	receptor 2 (HER2)-
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q8. Please indicate the patient's menopause status:		



EOC ID:

Kisqali-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 is postmenopausal ☐ The patient is premenopausal or perimenopausal ☐ None of the above	
Q9. Please select any of the following that apply to the patient: The medication will be used in combination with an aromatase inhibitor The medication will be used in combination with fulvestrant None of the above	
Prescriber Signature	Date



EOC ID:

Korlym-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applied	cable):
*Please note that Elixir will process the request as writte	en, including drug name, wi	th no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may suppestions and sign.	oort approval. Please answer the
<u> </u>	<u> </u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for this medicate	tion *	
☐ Endogenous Cushing's syndrome	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select any of the following that applies to the p	atient:	
☐ The patient has type 2 diabetes mellitus or glucose ☐ The medication will be used to control hyperglycemi		sm
☐ The patient has failed surgery	a coconaa.y to ny ponocinico	
☐ The patient is not a candidate for surgery		
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q7. Is the medication prescribed by or in consultation with	an endocrinologist?	



EOC ID:

Korlym-12 Medicare

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

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

Patient Name:	Prescriber Name:	
☐ Yes	□ No	
Q8. Does the patient have any of the following (please select all that apply)?		
☐ Pregnancy		
☐ Coadministration with simvastatin, lovastatin, or CYI	P3A substrates with narrow therapeutic ranges	
☐ Concomitant treatment with systemic corticosteroids	for serious medical conditions or illnesses	
☐ History of unexplained vaginal bleeding		
☐ Endometrial hyperplasia with atypia or endometrial carcinoma		
☐ None of the above		
Prescriber Signature		



EOC ID:

Koselugo-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (in	f applicable):
*Please note that Elixir will process the reque	st as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or fo	information for this patient that may ollowing questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therap	py?	
☐ Initial therapy	☐ Continuing the	тару
Q2. For CONTINUING THERAPY, please pro	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	he requested medication:	
☐ Neurofibromatosis type 1 (NF1)	☐ Other	
Q4. If the patient's diagnosis is OTHER, plea	se specify below:	
Q4. If the patient's diagnosis is OTHER, plea Q5. Does the patient have symptomatic, inoper-		?
, , ,		?
Q5. Does the patient have symptomatic, inoper-	able plexiform neurofibromas (PN) ☐ No	?
Q5. Does the patient have symptomatic, inoperation Yes	able plexiform neurofibromas (PN) ☐ No	?
Q5. Does the patient have symptomatic, inoperative of the patient between 2 to 17 years of age.	able plexiform neurofibromas (PN) No No	



EOC ID:

Koselugo-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Kuvan-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility na	me (if applicable):
*Please note that Elixir will process the request as writte	n, including drug	name, with no substitution.
	☐ Expedited	d/Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient tha estions and sign.	t may support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuin	g therapy
Q2. For CONTINUING THERAPY, please provide the sta	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	d medication: *	
☐ Hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU	J) Dther	
Q4. If the patient's diagnosis is OTHER, please specify b	pelow:	
Prescriber Signature		Date



EOC ID:

Lenvima-12 Medicare

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

Patient Name:	Prescriber Name:	
	rieschbei Name.	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	0.4.1.15
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP: Primary Phone:	City, State ZIP: Specialty/facility name (if applicable)	
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Discretions / Olo		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support a	oproval. Please answer the
	estions and sign.	sprovan r rouge anomer and
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ad medication:	
<u>_</u>	a medication.	
☐ Endometrial carcinoma (advanced)☐ Differentiated thyroid cancer (locally recurrent or metas	etatic progressive)	
Liver carcinoma (unresectable)	static, progressive)	
Renal cell carcinoma (advanced)		
Other		
Q4. For ENDOMETRIAL CARCINOMA, please select al	I that apply to this patient:	
·		ent
☐ The patient's disease is NOT microsatellite instability-high or mismatch repair deficient☐ The patient has had disease progression following prior systemic therapy		
☐ The patient has had disease progression following prior systemic therapy		
☐ None of the above	,	
Q5. For THYROID CANCER, is the patient's disease ref	ractory to radioactive iodine?	
☐ Yes	□ No	
Q6. For RENAL CELL CARCINOMA, please select all the	nat apply to this patient:	



EOC ID:

Lenvima-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 received at least one prior anti-angiogenic therapy ☐ The requested medication will be used in combination with everolimus ☐ None of the above 	
Q7. If the patient's diagnosis is OTHER, please specify b	pelow:
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Leukine-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writte	en, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Disease attack and months and months at history as information	a facthia maticut that me	and a supposed Disease a supposed to
Please attach any pertinent medical history or information following qu	itor this patient that ma estions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erany
		Стару
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requested	ed medication:	
Acute myeloid leukemia, following completion of induc	• •	
Allogeneic or autologous bone marrow transplant, delayed or failed engraftment		
Autologous peripheral blood progenitor cell transplant, mobilization of progenitor cells for collection by leukapheresis		
Hematopoietic subsyndrome of acute radiation syndro	,	
Myeloid reconstitution after autologous or allogeneic b	•	
Autologous peripheral blood stem cell transplant follow	ving myeloablative che	motnerapy
Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have excessive (greater than or equa	al to 10%) leukemic my	veloid blasts in bone marrow or
☐ Yes	□No	
Q6. Will the patient be receiving the requested medication	concomitantly with my	relosuppressive chemotherapy or



EOC ID:

Leukine-12 Medicare

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

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

Patient Name:	Prescriber Name:	
radiation?		
☐ Yes	□ No	
Prescriber Signature		Date



EOC ID:

Lidocaine Patch-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if ap	pplicable):
*Please note that Elixir will process the request as written	en, including drug name,	with no substitution.
☐ Expedited/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may so estions and sign.	upport approval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	у
Q2. For CONTINUING THERAPY, please indicate the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication: *	
☐ Post-herpetic neuralgia		
☐ Pain associated with diabetic neuropathy		
☐ Pain associated with cancer-related neuropathy		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Prescriber Signature		Date



EOC ID:

Lorbrena-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writte	en, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that ma	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient anaplastic lymphoma kinase (ALK)-posit	tive?	
☐ Yes	☐ No	
Q6. Please select any of the following that applies to the p	patient:	
☐ The patient had disease progression on either alect for metastatic disease	inib (Alecensa) or ceriti	inib (Zykadia) as the first ALK inhibitor
☐ The patient had disease progression on crizotinib (⟩ disease	(alkori) AND at least or	ne other ALK inhibitor for metastatic
☐ None of the above		
Q7. Will the requested medication be used concomitantly	with strong CYP3A4 in	ducers?



EOC ID:

Lorbrena-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Yes	□No
Q8. Is the patient 18 years of age or older?	
☐Yes	□ No
Q9. Is the requested medication being prescribed by, or in	consultation with, an oncologist?
☐Yes	□ No
Prescriber Signature	Date



EOC ID:

Lupron-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Otata Lia ID.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	(if applicable)
Primary Phone:	Specialty/facility name	
*Please note that Elixir will process the request as		
D 11 10 11	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide	e the start date (MM/YY):	
Q3. Please indicate the requested medication:		
Leuprolide Injection		
Lupron Depot (3.75 or 11.25 mg)		
Lupron Depot (7.5, 22.5, 30 or 45 mg)		
☐ Other		
Q4. If the requested medication is OTHER, please specify:		
Q5. Please indicate the patient's diagnosis for the re	equested medication:	
☐ Anemia caused by uterine leiomyomata (fibroids)		
Central precocious puberty (idiopathic or neurogenic) in a child		
☐ Endometriosis		
☐ Prostate cancer, advanced or metastatic		
☐ Other		
Q6. If the patient's diagnosis is OTHER, please s	pecify below.	



EOC ID:

Lupron-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 ANEMIA DUE TO UTERINE LEIOMYOMATA, is the patient preoperative?		
☐ Yes	□ No	
Q8. For PROSTATE CANCER, has the patient failed or is	intolerant to Eligard?	
☐ Yes	□ No	
Q9. If the patient has NOT tried Eligard, is there a reason history of adverse event, etc.)?	n why this medication cannot be used (i.e., contraindication,	
Q10. Please select all that apply to the patient:		
☐ Patient is pregnant (in patients with child-bearing po	tential)	
☐ Patient is breastfeeding		
Patient has undiagnosed abnormal vaginal bleeding		
☐ None of the above or not applicable		
Prescriber Signature		



EOC ID:

Lynparza-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D:1: / 010		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Advanced ovarian cancer		
☐ Breast cancer, metastatic		
☐ Epithelial ovarian, fallopian tube, or primary peritoneal	cancer	
☐ Pancreatic adenocarcinoma, metastatic		
☐ Prostate cancer, metastatic castration-resistant		
☐ Other		
Q4. For ADVANCED OVARIAN CANCER, please selec	t all that apply to this patient:	
☐ The patient has a known or suspected BRCA mu	itation as detected by an FDA-app	roved test
☐ The patient has had trial and failure, contraindica☐ None of the above	•	
Q5. For BREAST CANCER, please select all that apply	to this patient:	
☐ The patient's disease is human epidermal growth	n factor receptor 2 (HER2)-negativ	е
☐ The patient has deleterious or suspected deleter	, , , ,	
\square The patient has been previously treated with che	motherapy in the neoadjuvant, ad	juvant, or metastatic setting



EOC ID:

Lynparza-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, please select all that apply to this patient: The cancer is recurrent The cancer is advanced The requested medication will be used for maintenance treatment in a patient who is in complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin) The patient has deleterious or suspected deleterious germline or somatic BRCA mutation (gBRCAm or sBRCAm) The patient is in complete or partial response to first-line platinum-based chemotherapy The cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA-mutation, and/or genomic instability The requested medication is being used in combination with bevacizumab (Avastin) for maintenance		
treatment None of the above		
Q7. For PANCREATIC ADENOCARCINOMA, please set The patient has deleterious or suspected deleter The patient's disease has not progressed on at le regimen None of the above	***	
Q8. For PROSTATE CANCER, please select all that ap The patient has deleterious or suspected deleter (HRR) gene mutation The patient's disease has progressed following p None of the above	ious germline or somatic homologous recombination repair	
Q9. If the patient's diagnosis is OTHER, please specify	below:	
Prescriber Signature		



EOC ID:

Mayzent-14 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Relapsing forms of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or ☐ Other		
active secondary progressive disease)		
Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Has the patient previously tried and failed any of the fo	ollowing medications?	
Avonex		
Betaseron		
Glatiramer		
Gilenya		
☐ None of the above		



EOC ID:

Mayzent-14 Medicare

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

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

Patient Name:	Prescriber Name:	
Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?		
Q8. Is the requested medication prescribed by (or in consu	ıltation with) a neurologist?	
☐ Yes	□ No	
Q9. Does the patient have any of the following (please sele	ect all that apply)?	
☐ In the last 6 months, has experienced myocardial infailure requiring hospitalization, or Class III-IV heart failure	farction, unstable angina, stroke, TIA, decompensated heart	
☐ Presence of Mobitz type II second-degree, third-deg functioning pacemaker	ree AV block, or sick sinus syndrome, unless patient has a	
None of the above		
Prescriber Signature		



EOC ID:

Mekinist-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
	conons and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Anaplastic thyroid cancer, locally advanced or metasta	tic	
Malignant melanoma		
Non-small cell lung cancer, metastatic		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For ANAPLASTIC THYROID CANCER, does the patie	ent have no satisfactory locoregion	nal treatment options?
☐ Yes	□No	
Q6. For ANAPLASTIC THRYOID CANCER OR NON-SMA V600E mutation?	LL CELL LUNG CANCER, does t	he patient have BRAF
☐ Yes	□ No	
Q7. For MALIGNANT MELANOMA, please select all that a	apply to this patient:	



EOC ID:

Mekinist-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ The patient has BRAF V600E or V600K mutations ☐ The patient's disease is unresectable or metastatic ☐ The requested medication will be used as monother. ☐ The patient has lymph node involvement, following of the above	. ,
Q8. Will the requested medication be used in combination	with dabrafenib (Tafinlar)?
☐ Yes	□ No
Q9. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q10. Is the requested medication being prescribed by, or in	n consultation with, an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Mektovi-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable	·):	
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	approval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Malignant melanoma, unresectable or metastatic	☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify bel	ow:		
Q5. Does the patient have documented BRAF V600E or V	600K mutation as detected by a F	DA-approved test?	
☐ Yes	□ No		
Q6. Will the requested medication be used in combination	with encorafenib (Braftovi)?		
☐ Yes	□ No		
Q7. Is the patient 18 years of age or older?			
☐ Yes	□ No		
Q8. Is the requested medication being prescribed by, or in	consultation with, an oncologist?		
☐ Yes	□ No		



EOC ID:

Mektovi-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Methylphenidates-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information	n for this patient that may support a	approval. Please answer the	
Tollowing qui	estions and sign.		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Attention deficit hyperactivity disorder (ADHD)			
□ Narcolepsy			
☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify	helow.		
a and patients diagnosis is a rriant, please speen,			
Q5. For NARCOLEPSY, please select all that apply:			
☐ The diagnosis of narcolepsy has been confirmed by a sleep study			
☐ The prescriber has provided justification confirming that a sleep study would not be feasible			
☐ None of the above	,		
Q6. If a sleep study is not feasible, please provide justifi	cation:		
Q7. Does the patient have any of the following (please sele	ect all that apply)?		
a 2000 the patient have any or the following (please self			



EOC ID:

Methylphenidates-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Symptoms of marked anxiety, tension, or agitation ☐ Glaucoma ☐ Family history/diagnosis of Tourette's syndrome or p ☐ Concurrent use with MAOIs ☐ None of the above	presence of motor tics
Prescriber Signature	



EOC ID:

Miglustat-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writ	tten, including drug na	nme, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that muestions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Gaucher disease, type 1 (mild to moderate)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Is the patient a candidate for enzyme replacement th	erapy?	
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Miglustat-12 Medicare

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

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

Patient Name:	Prescriber Name:

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EOC ID:

Multiple Sclerosis-14 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following que	for this patient that may support apestions and sign.	oproval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):		
Q3. Please indicate which medication is being requested b	elow:		
☐ Avonex			
☐ Betaseron			
☐ Gilenya			
☐ Glatiramer/Copaxone			
 □ Tecfidera			
Q4. For GILENYA, does the patient have any of the follo	wing (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 the			
patient has a pacemaker			
☐ Baseline QTc interval greater than or equal to 50	0 milliseconds		
☐ Receiving concurrent treatment with Class Ia or	Class III anti-arrhythmic drugs (suc	:h as quinidine,	
procainamide, amiodarone, or sotalol)			
☐ None of the above			



EOC ID:

Multiple Sclerosis-14 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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. Please indicate the patient's diagnosis for the requeste	ed medication:
progressive disease, or progressive-relapsing MS)	olated syndrome, relapsing-remitting MS, active secondary
☐ Experienced a first clinical episode and has MRI featur☐ Other	res consistent with multiple sclerosis
Q6. If the patient's diagnosis is OTHER, please specify	below:
Q7. Is the patient 18 years of age or older?	
☐ Yes	□ No
Prescriber Signature	



EOC ID:

Natpara-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as wri	tten, including drug na	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati following of	on for this patient that m questions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Hypoparathyroidism	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Will the requested medication be used to control hyp	ocalcemia?	
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Natpara-12 Medicare

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

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

Patient Name:	Prescriber Name:

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EOC ID:

Nerlynx-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Breast cancer	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient's disease human epidermal growth facto	r receptor 2 (HER2)-positive?	
☐ Yes	□ No	
Q6. Please select all that apply to this patient:		
☐ The patient's disease is early-stage		
☐ The patient's disease is advanced or metastatic		
☐ The patient has received adjuvant trastuzumab based therapy		
☐ The patient has received 2 or more prior anti-HER2 based regimens in the metastatic setting, in combination with		
capecitabine		
☐ None of the above		



EOC ID:

Nerlynx-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q8. Is the requested medication prescribed by (or in consu	ıltation with) an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Ninlaro-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the reques	st as written, including drug nam	e, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or fo	information for this patient that may blowing questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therap	py?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please pro	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	ne requested medication:	
☐ Multiple myeloma	☐ Other	
Q4. If the patient's diagnosis is OTHER, pleas	se specify below.	
Q5. Will the requested medication be used in co	ombination with lenalidomide (Revli	mid) and dexamethasone?
☐ Yes	□No	,
Q6. Does the patient have history of at least one	e prior therapy?	
☐ Yes	☐ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□No	



EOC ID:

Ninlaro-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Northera-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Elixir will process the reque	est as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or f	information for this patient that may ollowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing thera	py?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, please pi	rovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	the requested medication:	
☐ Neurogenic orthostatic hypotension (NOI	d) ☐ Other	
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Is the patient symptomatic?		
	□No	
☐ Yes		
☐ Yes Q6. Is the patient's diagnosis caused by one of		apply)?
	the following (please select all that	,



EOC ID:

Northera-12 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Nubeqa-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility nan	ne (if applicable):
*Please note that Elixir will process the request as writte	en, including drug	name, with no substitution.
	☐ Expedited/	Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that estions and sign.	may support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing	therapy
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Prostate cancer (non-metastatic, castration-resistant)	Other	
Q4. If the patient's diagnosis is OTHER, please specify t	pelow:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Is the requested medication prescribed by, or in consu	Itation with, an onco	ologist or urologist?
☐ Yes	☐ No	
Prescriber Signature		Date

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EOC ID:

Nubeqa-12 Medicare

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Patient Name:	Prescriber Name:

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EOC ID:

Nucala-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Severe asthma with eosinophilic phenotype		
☐ Eosinophilic granulomatosis with polyangiitis (EGPA)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Is the patient 6 years of age or older?		
☐ Yes	□ No	
Q6. Is the requested medication prescribed by, or in consummunologist?	Itation with, a pulmonologist, rheu	matologist, or
☐ Yes	□ No	



EOC ID:

Nucala-12 Medicare

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

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Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Nuedexta-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
T		
Directions / SIG:		
Diagon ette ele any montinent modicel bietem en information	for this notion that many arms out or	annered Diagon angurer tha
Please attach any pertinent medical history or information following que	estions and sign.	oproval. Flease allswer tile
O1 to this request for initial or continuing thereas?		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Pseudobulbar affect (PBA)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q II alio padolico diagnosio io o milin, piedos oposily i	30.011.	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Is the requested medication prescribed by, or in consu	Itation with, a neurologist?	
☐ Yes	☐ No	
Q7. Does the patient have any of the following (please sele	ect all that apply)?	
☐ History of prolonged QT interval, congenital long QT	syndrome or Torsades de pointes	3
☐ Heart failure	,	
☐ Complete AV block without an implanted pacemake	or high risk of complete AV block	
☐ Concomitant use with quinidine, quinine, mefloquine	, or drugs that prolong QT interval	and are metabolized by



EOC ID:

Nuedexta-12 Medicare

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

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

Patient Name:	Prescriber Name:	
CYP2D6 (such as thioridazine, pimozide) Concomitant use with monoamine oxidase inhibitors None of the above	ors (MAOIs) or within 14 days of MAOI therapy	
	<u> </u>	
Prescriber Signature	Date	



EOC ID:

Nuplazid-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the reques	t as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or i	nformation for this patient that ma llowing questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therap	y?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please pro	vide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	ne requested medication:	
☐ Parkinson's disease psychosis	☐ Other	
Q4. If the patient's diagnosis is OTHER, pleas	se specify below:	
Q5. Is the patient experiencing hallucinations an	d/or delusions?	
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
Prescriber Signature		Date



EOC ID:

Nuplazid-12 Medicare

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

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

Patient Name:	Prescriber Name:

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EOC ID:

Octreotide-11 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable)	:	
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information	o for this nationt that may support a	oproval Places answer the	
	estions and sign.	pprovai. I lease allswer tile	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Acromegaly			
☐ Metastatic carcinoid syndrome			
☐ Vasoactive intestinal peptide-secreting tumor (VIPoma) with associated diarrhea		
Other			
Q4. If the patient's diagnosis is OTHER, please specify below.			
Q5. For ACROMEGALY, has the patient had an inadequate response to, or is ineligible for, any of the following (please			
select all that apply)?			
☐ Surgery ☐ Radiation			
☐ Bromocriptine mesylate			
None of the above			
Q6. If the patient has NOT tried any of the options listed	in the previous question, is there	a reason these ontions	
cannot be used (i.e., contraindication, history of adverse	·		



EOC ID:

Octreotide-11 Medicare

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

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

Patient Name:	Prescriber Name:	
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		 Date



EOC ID:

Opsumit-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writ	tten, including drug na	ame, with no substitution.
	☐ Expedited/Ui	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this patient that muestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Pulmonary arterial hypertension, World Health Organization group 1	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Was the patient's diagnosis confirmed by right heart unable to undergo a right heart catheterization (e.g., patie	• • • • • • • • • • • • • • • • • • • •	
☐ Yes	□No	
Q6. Is the patient pregnant?		
Yes		
□ No		
☐ Not applicable - patient is not a female of child-bearir	ng potential	



EOC ID:

Opsumit-13 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Orilissa-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Moderate to severe pain associated with endometriosis	Other	
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Does the patient have any of the following (please select all that apply)? Pregnancy Known osteoporosis Severe hepatic impairment Current use of strong organic anion transporting polypeptide (OATP) 1B1 inhibitors None of the above		



EOC ID:

Orilissa-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Orkambi-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	f applicable):
*Please note that Elixir will process the r	equest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ry or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing	herapy?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, plea	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	s for the requested medication:	
☐ Cystic Fibrosis (CF)	☐ Other	
Q4. If the patient's diagnosis is OTHER	, please specify below:	
Q5. Does the patient have documented hotest?	omozygous F508del mutation as confirm	ed by a FDA-approved CF mutation
Yes	□No	
Q6. Is the requested medication prescribe a CF center accredited by the Cystic Fibro	· ·	ogist or prescribing practitioner from
☐ Yes	□ No	
Prescriber Signature		Date



EOC ID:

Orkambi-12 Medicare

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

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

Patient Name:	Prescriber Name:



EOC ID:

Osphena-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Elixir will process the reque	est as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history of	r information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing thera	py?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please p	rovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	the requested medication:	
☐ Moderate to severe dyspareunia due to	vulvar and vaginal atrophy associat	ed with menopause
☐ Moderate to severe vaginal dryness due☐ Other	to vulvar and vaginal atrophy asso	ciated with menopause
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q6. Does the patient have any of the following	(please select all that apply)?	
☐ Undiagnosed abnormal genital bleeding		
☐ Known or suspected estrogen-depender	nt neoplasia	
Active or history of deep vein thrombosis	, ,	
☐ Active or history of pulmonary embolism		
Active or history of arterial thromboembo	olic disease	



EOC ID:

Osphena-12 Medicare

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

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

Patient Name:	Prescriber Name:	
☐ Pregnancy ☐ None of the above		
Prescriber Signature		Date



EOC ID:

Oxandrolone-11 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Adjunct therapy to promote weight gain	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Does the patient have any of the following (please selections	,	siologic reasons
Q6. Does the patient have any of the following (please sele	ect all that apply)?	



EOC ID:

Oxandrolone-11 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Breast cancer in women with hypercalcemia ☐ Pregnancy ☐ Nephrosis or nephrotic phase of nephritis ☐ Hypercalcemia ☐ None of the above	
Prescriber Signature	Date



EOC ID:

PCSK9 Inhibitors-14 Medicare

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

Member/Subscriber Number: Date of Birth: Group Number: Address: City, State ZIP: Primary Phone: *Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent Expedited/Ur			
Date of Birth: Group Number: Group Number: Address: City, State ZIP: Primary Phone: Please note that Elixir will process the request as written, including drug name, with no substitution. Drug Name and Strength: Directions / SIG: Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy Continuing therapy Q2. For continuing therapy, please specify start date (MM/YY): Q3. Please indicate which medication this request is for: Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HoFH) Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HoFH) Clinical Atherosclerotic Cardiovascular Disease (CVD) Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD Other Q5. 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 Ganthorna before 10 years of age Documentation of HeFH in both parents	Patient Name:	Prescriber Name:	
Group Number: Address: Address: City, State ZIP: Primary Phone: Specialty/facility name (if applicable): Specialty/facilit	Member/Subscriber Number:	Fax:	Phone:
Address: City. State ZIP: City. State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Date of Birth:	Office Contact:	
City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. **Drug Name and Strength:** Directions / SIG: **Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. **Q1. Is this request for initial or continuing therapy? Initial therapy	Group Number:	NPI:	State Lic ID:
Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution.	Address:		
Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	•	•	
Expedited/Urgent Directions / SIG: Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy?	Primary Phone:	Specialty/facility name (if applicable):	
Directions / SIG: Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy		☐ Expedited/Urgent	
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	Drug Name and Strength:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	D: 1: 1010		
Q1. Is this request for initial or continuing therapy? Initial therapy	Directions / SIG:		
Q1. Is this request for initial or continuing therapy? Initial therapy	Diago ettech any neutineut madical history as information	for this nation that may support or	annoval Diagon angusar the
□ Initial therapy □ Continuing therapy Q2. For continuing therapy, please specify start date (MM/YY): Q3. Please indicate which medication this request is for: □ Praluent □ Repatha Q4. Please indicate the patient's diagnosis for the requested medication: □ Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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			oproval. Flease allswer tile
□ Initial therapy □ Continuing therapy Q2. For continuing therapy, please specify start date (MM/YY): Q3. Please indicate which medication this request is for: □ Praluent □ Repatha Q4. Please indicate the patient's diagnosis for the requested medication: □ Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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			
□ Initial therapy □ Continuing therapy Q2. For continuing therapy, please specify start date (MM/YY): Q3. Please indicate which medication this request is for: □ Praluent □ Repatha Q4. Please indicate the patient's diagnosis for the requested medication: □ Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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			
Q2. For continuing therapy, please specify start date (MM/YY): Q3. Please indicate which medication this request is for: Praluent Q4. Please indicate the patient's diagnosis for the requested medication: Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) Clinical Atherosclerotic Cardiovascular Disease (CVD) Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD Other Q5. 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	Q1. Is this request for initial or continuing therapy?		
Q3. Please indicate which medication this request is for: Praluent Q4. Please indicate the patient's diagnosis for the requested medication: Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) Clinical Atherosclerotic Cardiovascular Disease (CVD) Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD Other Q5. 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	☐ Initial therapy	☐ Continuing therapy	
Q3. Please indicate which medication this request is for: Praluent Q4. Please indicate the patient's diagnosis for the requested medication: Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) Clinical Atherosclerotic Cardiovascular Disease (CVD) Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD Other Q5. 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	O2 For continuing therapy, please specify start date (M	M/YY)·	
□ Praluent □ Repatha Q4. Please indicate the patient's diagnosis for the requested medication: □ Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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	Q2. 1 of continuing thorapy, please speenly start date (in		
□ Praluent □ Repatha Q4. Please indicate the patient's diagnosis for the requested medication: □ Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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	O2 Places indicate which medication this request is few		
Q4. Please indicate the patient's diagnosis for the requested medication: Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) Clinical Atherosclerotic Cardiovascular Disease (CVD) Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD Other Q5. 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	· _	_	
 □ Primary hyperlipidemia (hypercholesterolemia) Heterozygous Familial Hypercholesterolemia (HeFH) □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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 	Praluent	∐ Repatha	
 □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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 	Q4. Please indicate the patient's diagnosis for the requeste	ed medication:	
 □ Primary hyperlipidemia Homozygous Familial Hypercholesterolemia (HoFH) □ Clinical Atherosclerotic Cardiovascular Disease (CVD) □ Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD □ Other Q5. 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 	☐ Primary hyperlipidemia (hypercholesterolemia) Heteroz	zygous Familial Hypercholesteroler	mia (HeFH)
 Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD Other Q5. 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 		• • • • • • • • • • • • • • • • • • • •	,
established CVD Other Q5. 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	☐ Clinical Atherosclerotic Cardiovascular Disease (CVD)		
☐ Other Q5. 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	☐ Myocardial infarction prophylaxis, stroke prophylaxis, a	and to reduce risk of coronary revas	scularization in patients with
Q5. 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			
☐ Genotyping ☐ History of untreated LDL-C greater than 500 mg/dL ☐ Xanthoma before 10 years of age ☐ Documentation of HeFH in both parents	│		
 ☐ History of untreated LDL-C greater than 500 mg/dL ☐ Xanthoma before 10 years of age ☐ Documentation of HeFH in both parents 	Q5. For HoFH, has the diagnosis been confirmed by any	of the following? (please select al	I that apply):
☐ Xanthoma before 10 years of age☐ Documentation of HeFH in both parents	☐ Genotyping		
☐ Documentation of HeFH in both parents	☐ History of untreated LDL-C greater than 500 mg/	dL	
	☐ Xanthoma before 10 years of age		
☐ None of the above	· ·		
	☐ None of the above		



EOC ID:

PCSK9 Inhibitors-14 Medicare

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

Patient Name:	Prescriber Name:
Q6. FOR CARDIOVASCULAR DISEASE: has the patient apply):	nt experienced any of the following? (please select all that
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	e atherosclerotic region
☐ None of the above	
Q7. If the patient's diagnosis is OTHER, please specify	below:
Q8. Please provide the patient's baseline and current LDL-	-C cholesterol levels below:
Q9. Please select all that apply to this patient:	
Patient's LDL-C level is greater than or equal to 70 r	
	on with maximally tolerated high-intensity statin therapy
Statins are not tolerated by the patient	
☐ None of the above	
Q10. If statins are contraindicated or not tolerated by the	e patient, please explain below:
Q11. Is the medication being prescribed by, or in consultat	ion, with any of the following provider specialties?
☐ Cardiologist	
Endocrinologist	
Lipid specialist	
☐ None of the above	
Q12. FOR CONTINUING THERAPY: please select all that	apply to this patient:
☐ The requested medication will continue to be used in	n combination with maximally tolerated statin
☐ Statin therapy is not tolerated by the patient	
☐ None of the above	
Prescriber Signature	Date



EOC ID:

PCSK9 Inhibitors-14 Medicare

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

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

Patient Name:	Prescriber Name:
This telecopy transmission contains confidential information belonging to the sender th	at is legally privileged. This information is intended only for the use of the in



EOC ID:

Pegasys-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Filone.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writte	en, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Directions / GIG.		
Please attach any pertinent medical history or information following qu	n for this patient that ma	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic hepatitis B☐ Chronic hep		☐ Other
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the requested medication prescribed by, or in consu	ultation with any of the	following (please select all that
apply)?	,,	, , , , , , , , , , , , , , , , , , ,
Gastroenterologist		
☐ Hepatologist		
☐ Infectious disease specialist		
☐ None of the above		
Q6. Does the patient have any of the following (please sele	ect all that apply)?	
☐ Autoimmune hepatitis or other autoimmune conditio	n known to be exacerb	pated by interferon
☐ Uncontrolled depression		
☐ None of the above		



EOC ID:

Pegasys-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 HEPATITIS C: Please provide the patient's genoty	pe below:
Q8. For HEPATITIS C: Please provide the patient's initial I RNA level and week of treatment:	HCV RNA level and, if continuing therapy, the current HCV
Q9. For HEPATITIS C: Will the requested medication be u	sed in conjunction with Sovaldi?
☐ Yes	□ No
Q10. For HEPATITIS C: Is the patient treatment-naive or e	experienced?
☐ Treatment naive (i.e., has never been treated for hepatitis C)	☐ Treatment experienced (i.e., has received treatment for hepatitis C in the past)
Q11. For HEPATITIS C: Please indicate all treatments the (i.e., non-responder, relapser, etc.):	patient has previously tried and the outcome of treatment
Q12. For HEPATITIS C: Please indicate all medications th	at will be part of the treatment regimen:
Q13. For HEPATITIS C: Please indicate the anticipated du	ration of therapy for this patient:
Q14. For HEPATITIS C: Does the patient have cirrhosis?	
☐ Yes	□ No
Q15. Does the patient have compensated liver disease?	
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Pemazyre-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:	•	
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support a	pproval. Please answer the
	osuono una orgin	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Cholangiocarcinoma, unresectable locally advanced metastatic	or	
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Has the patient been previously treated?		
☐ Yes	□ No	
Q6. Does the patient's disease have confirmed fibroblast g rearrangement as detected by a FDA-approved test?	rowth factor receptor 2 (FGFR2) f	usion or other
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	



EOC ID:

Pemazyre-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Is the requested medication prescribed by or in conshepatologist?	sultation with an oncologist, gastroenterologist, or
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Piqray-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writt	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a lestions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Breast cancer, advanced or metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient's disease hormone receptor (HR)-positive?	ve, and human epidermal growth fa	actor receptor 2 (HER2)-
☐ Yes	□ No	
Q6. Is the patient's cancer PIK3CA-mutated?		
☐ Yes	□ No	
Q7. Please select all that apply to this patient:		
☐ The patient is a male or postmenopausal woman		
☐ The requested medication will be used in combinati☐ The patient's disease has progressed on or after an		



EOC ID:

Pigray-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ None of the above	
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q9. Is the requested medication prescribed by (or in consu	ıltation with) an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Pomalyst-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	THORC.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Discretions / OIO		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support apestions and sign.	pproval. Please answer the
Tonowing que	ostions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Multiple myeloma	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. Please select all that apply to the patient:		
☐ Disease has progressed on or within 60 days of com	pletion of the last therapy	
☐ Patient has been counseled about the use of two for		e, during, and one month
after discontinuing therapy		
Patient has been assessed to determine if prophylad	•	nent (warfarin, clopidogrel)
will need to be taken to reduce the risk of VTE (embolism, Patient is registered and certified to be compliant with		
☐ None of the above	III Follialyst KEIVIS program	
Q6. For FEMALES OF CHILD-BEARING POTENTIAL, ple	ase select all that apply:	
☐ Patient is not pregnant	and colour all that apply.	



EOC ID:

Pomalyst-12 Medicare

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

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

Patient Name:	Prescriber Name:
 ☐ Two negative pregnancy tests have been obtained ☐ Patient will receive monthly pregnancy tests during ☐ Patient is male or not of reproductive potential ☐ None of the above 	
Prescriber Signature	 Date



EOC ID:

Promacta-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the req	uest as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that ma following questions and sign.	y support approval. Please answer the
O1 to this request for initial or continuing the	orany?	
Q1. Is this request for initial or continuing the		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	or the requested medication:	
☐ Chronic idiopathic thrombocytopenic pur	pura (ITP)	
☐ Severe aplastic anemia		
Thrombocytopenia associated with chro	nic hepatitis C infection	
☐ Other		
Q4. If the patient's diagnosis is OTHER, p	please specify below:	
Q5. For APLASTIC ANEMIA, please select	any of the following that apply to the p	patient:
☐ The patient had an insufficient respon	se to immunosuppressive therapy	
☐ The requested medication will be use		nosuppressive therapy
☐ None of the above		
Prescriber Signature		Date



EOC ID:

Promacta-12 Medicare

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

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

	e: Pi	Prescriber Name:
This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the indiv	nsmission contains confidential information belonging to the sender that is	s legally privileged. This information is intended only for the use of the individua



EOC ID:

Qinlock-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writ	ten, including drug na	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that muestions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Gastrointestinal stromal tumor, advanced	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Has the patient received prior treatment with 3 or mo	re kinase inhibitors, inc	luding imatinib?
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Prescriber Signature		Date



EOC ID:

Qinlock-12 Medicare

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

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

Patient Name:	Prescriber Name:

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EOC ID:

Regranex-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	if applicable):
*Please note that Elixir will process the request	as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or interest follo	formation for this patient that ma owing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy	?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, please provi	ide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	requested medication below:	
☐ Lower extremity diabetic neuropathic ulcer	☐ Other	
Q4. If the patient's diagnosis is OTHER, please	specify below:	
Q5. Does the ulcer extend into the subcutaneous	tissue or beyond and have an a	dequate blood supply?
☐ Yes	☐ No	
Q6. Is the patient 16 years of age or older?		
☐ Yes	☐ No	
Q7. Does the patient have a known neoplasm at t	he site of application?	
☐ Yes	☐ No	



EOC ID:

Regranex-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Retevmo-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support a	pproval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Medullary thyroid cancer, RET-mutant (advanced or		
☐ Non-small cell lung cancer, RET fusion-positive (me	,	
☐ Thyroid cancer, RET fusion-positive (advanced or m	· ·	
☐ Other		
Q4. For MEDULLARY THYROID CANCER, does the pa	atient require systemic therapy (su	ch as the requested
☐ Yes	□No	
Q5. For THYROID CANCER, please select all that apply	to this patient:	
$\hfill\Box$ The patient requires systemic therapy (such as the	ne requested medication)	
The patient is refractory to radioactive iodine, if a	ppropriate	
☐ None of the above		
Q6. If the patient's diagnosis is OTHER, please specify l	below:	



EOC ID:

Retevmo-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the requested medication prescribed by (or in consu	ıltation with) an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Revlimid-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
	. for this mations that many arranges as	namental Disease annual the
Please attach any pertinent medical history or information following que	estions and sign.	pprovai. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Follicular lymphoma		
☐ Mantle cell lymphoma		
☐ Marginal zone lymphoma		
☐ Multiple myeloma		
☐ Transfusion-dependent anemia		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow.	
Q4. If the patient's diagnosis is Official, piease specify	ociow.	
OF FEE FOLLIGHIAD LYMPHOMA ST MADOINAL ZONE	LVAADULONAAill thee meen eete dine	a diantina ha wasalia
Q5. For FOLLICULAR LYMPHOMA or MARGINAL ZONE combination with rituximab (Rituxan)?	LYMPHOMA, will the requested m	ledication be used in
, '	□Ne	
Yes	□ No	
Q6. For MANTLE CELL LYMPHOMA, has the patient's dis (one of which included bortezomib [Velcade])?	ease relapsed or progressed after	two (2) prior therapies



EOC ID:

Revlimid-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Yes	□ No
Q7. For MULTIPLE MYELOMA, please indicate how the religious in combination with dexamethasone Following autologous hematopoietic stem cell transpose None of the above	
Q8. For TRANSFUSION-DEPENDENT ANEMIA, is the pa myelodysplastic syndrome (MDS) associated with a deletic cytogenetic abnormalities?	
☐ Yes	□ No
Q9. Is the patient pregnant?	
☐ No ☐ Not applicable - the patient is not a female of child-bea	ring potential
Prescriber Signature	Date



EOC ID:

Rinvoq-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as wr	itten, including drug na	ame, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informat following	ion for this patient that m questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Rheumatoid arthritis, moderate to severe	☐ Other	
Q4. If the patient's diagnosis is OTHER, please speci	fy below:	
Q5. Has the patient had an inadequate response or into	lerance to methotrexate	?
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Rinvoq-12 Medicare

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

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

Patient Name:	Prescriber Name:

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EOC ID:

Rozlytrek-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	i):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this nationt that may sunnort a	annroval Please answer the
	estions and sign.	ipprovan r loudo unovor the
Od to this group of facilities an application the compa		
Q1. Is this request for initial or continuing therapy?	_	
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
ROS1-positive metastatic non-small cell lung cance	r (NSCLC)	
Solid tumors	. ()	
Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow	
Q4. If the patient's diagnosis is OTTLEN, please specify	below.	
Q5. For SOLID TUMORS, please select all that apply to the	no nationt:	
	•	a longerous a constitue d
☐ The disease has a neurotrophic tyrosine receptor ki resistance mutation	nase (NTRK) gene fusion without	a known acquired
The disease is metastatic or surgical resection is lik	ely to result in severe morbidity	
☐ The disease has either progressed following treatments		ve therany
None of the above	one of has no satisfactory alternati	ve therapy
Q6. Is the requested medication prescribed by, or in consu	ultation with an oncologist?	
	_	
Yes	□ No	



EOC ID:

Rozlytrek-12 Medicare

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

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

Patient Name:	Pr	escriber Name	9 :
	•		
		_	
Prescriber Signature			Date



EOC ID:

Rubraca-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Elixir will process the request as writte	en, including drug name	e, with no substitution.
	☐ Expedited/Urgen	ıt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may sestions and sign.	support approval. Please answer the
Tonowing qui	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Deleterious BRCA mutation (germline and/or somati	c)-associated ovarian, fal	llopian tube, or primary peritoneal
cancer		
☐ Recurrent ovarian, fallopian tube, or primary periton☐ Other	eal cancer	
_		
Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
Q5. Please select all that apply to the patient:		
The patient is BRCA mutation-positive as detected by		•
The patient has had previous trial with inadequate re		, , <u>, , , , , , , , , , , , , , , , , </u>
☐ The patient has had a complete or partial response t	•	therapy
☐ The requested medication will be used as monother	• •	
☐ The provider agrees to perform a complete blood co	unt (CBC) at baseline an	d monthly thereafter
☐ None of the above		



EOC ID:

Rubraca-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 PATIENTS OF CHILD-BEARING POTENTIAL, will therapy and for 6 months after the last dose?	I an effective method of contraception be used during	
☐Yes		
☐ No☐ N/A - The patient is not of child-bearing potential		
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q8. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?		
☐ Yes	□ No	
Q9. For CONTINUING THERAPY, has the patient experies	nced disease progression or unacceptable toxicity?	
☐ Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Rydapt-12 Medicare

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

Patient Name:	Prescriber Name:			
Member/Subscriber Number:	Fax:	Phone:		
Date of Birth:	Office Contact:			
Group Number:	NPI:	State Lic ID:		
Address:	Address:			
City, State ZIP:	City, State ZIP:			
Primary Phone:	Specialty/facility name (i	f applicable):		
*Please note that Elixir will process the reque	st as written, including drug nan	ne, with no substitution.		
	☐ Expedited/Urg	ent		
Drug Name and Strength:				
Directions / SIG:				
Please attach any pertinent medical history or	information for this patient that may ollowing questions and sign.	y support approval. Please answer the		
Q1. Is this request for initial or continuing thera	py?			
☐ Initial therapy	☐ Continuing the	гару		
Q2. For CONTINUING THERAPY, please pr	ovide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for t	he requested medication:			
☐ Acute myelogenous leukemia (AML)				
☐ Mast cell leukemia				
☐ Systemic mastocytosis				
☐ Other				
Q4. If the patient's diagnosis is OTHER, plea	use specify below:			
Q5. For ACUTE MYELOGENOUS LEUKEMIA,	please select all that apply to the	patient:		
☐ The patient is treatment naive				
☐ The patient is FLT3 mutation-positive				
☐ The requested medication will be used in combination with standard cytarabine and daunorubicin induction and				
consolidation therapy				
☐ None of the above				
Q6. Is the patient 18 years of age or older?				



EOC ID:

Rydapt-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Yes	□No
Q7. Is the requested medication prescribed by, or in consu	ltation with, an oncologist or hematologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Samsca-12 Medicare

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

Patient Name:	Prescriber Name:			
Member/Subscriber Number:	Fax:	Phone:		
Date of Birth:	Office Contact:			
Group Number:	NPI:	State Lic ID:		
Address:	Address:			
City, State ZIP:	City, State ZIP:			
Primary Phone:	Specialty/facility name (if applicable)):		
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.		
	☐ Expedited/Urgent			
Drug Name and Strength:				
Directions / SIG:				
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the		
Q1. Is this request for initial or continuing therapy?				
☐ Initial therapy	☐ Continuing therapy			
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:			
☐ Clinically significant hypervolemic or euvolemic hyponatremia, including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH)	☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify	below:			
Q5. Is the patient's serum sodium less than 125 mEq/L or resisted correction with fluid restriction?	less with marked hyponatremia tha	at is symptomatic and has		
☐ Yes	□ No			
Q6. Is the patient 18 years of age or older?				
☐ Yes	□ No			
Q7. Does the patient have any of the following (please sele	ect all that apply)?			



EOC ID:

Samsca-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ Hypovolemic hyponatremia ☐ Inability to sense or respond to thirst ☐ Urgent need to raise serum sodium acutely ☐ None of the above	
Prescriber Signature	



EOC ID:

Sildenafil-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Elixir will process the	request as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical hist	ory or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosi	s for the requested medication:	
☐ Pulmonary arterial hypertension (PA	AH), WHO Group 1	
Q4. If the patient's diagnosis is OTHEF	R, please specify below:	
Q5. Was the patient's diagnosis confirmed unable to undergo a right heart catheteriz		er echocardiogram if the patient is
☐ Yes	□ No	
Q6. Is the patient currently on nitrate there	ару?	
☐ Yes	□No	
Prescriber Signature		Date



EOC ID:

Sildenafil-12 Medicare

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

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

Patient Name:			Prescr	iber N	lame:						



EOC ID:

Skyrizi-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request a	s written, including drug na	me, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or info	rmation for this patient that ma	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provid	e the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the re	equested medication:	
☐ Plaque psoriasis, moderate to severe	☐ Other	
Q4. If the patient's diagnosis is OTHER, please s	specify below:	
Q5. Is the patient an adult who is a candidate for sy phototherapy?	stemic therapy (such as the r	equested medication) or
☐Yes	□No	
Prescriber Signature		Date



EOC ID:

Somatuline-12 Medicare

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

Patient Name:	Prescriber Name:			
Member/Subscriber Number:	Fax:	Phone:		
Date of Birth:	Office Contact:			
Group Number:	NPI:	State Lic ID:		
Address:	Address:			
City, State ZIP:	City, State ZIP:			
Primary Phone:	Specialty/facility name (if applicable)	:		
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.		
	☐ Expedited/Urgent			
Drug Name and Strength:				
Directions / SIG:				
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the		
Q1. Is this request for initial or continuing therapy?				
☐ Initial therapy	☐ Initial therapy ☐ Continuing therapy			
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:			
☐ Acromegaly				
☐ Carcinoid syndrome				
☐ Gastroenteropancreatic neuroendocrine tumors (GEP-	NETs)			
☐ Other	-,			
Q4. If the patient's diagnosis is OTHER, please specify	below:			
Q5. For ACROMEGALY, please select any of the following	that apply to the patient:			
☐ Patient had an inadequate response to surgery and/	or radiation			
☐ Patient is ineligible for surgery and/or radiation				
☐ None of the above				
Q6. Is the patient 18 years of age or older?				
	□No			
☐ Yes	□ No			



EOC ID:

Somatuline-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Somavert-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	э):
*Please note that Elixir will process the request as writte	en, including drug name, with r	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Acromegaly	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select any of the following that appy to the pati	ent:	
☐ Patient had an inadequate response to surgery and ☐ Patient is ineligible for surgery and/or radiation there	• •	
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Is the requested medication prescribed by, or in consu	ultation with, an endocrinologist?	
☐ Yes	□No	



EOC ID:

Somavert-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Sprycel-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Philadelphia chromosome-positive acute lymphoblastic	c leukemia (Ph+ ALL)	
☐ Philadelphia chromosome-positive chronic myelogenou☐ Other	us leukemia (Ph+ CML)	
Q4. If the patient's diagnosis is OTHER, please specify below.		
Q5. For ACUTE LYMPHOBLASTIC LEUKEMIA, please se	lect any of the following that apply	to the patient:
☐ Patient had resistance or intolerance to prior therapy		
☐ Disease is newly diagnosed and the requested medication will be used in combination with chemotherapy☐ None of the above		
Q6. For CHRONIC MYELOGEOUS LEUKEMIA, please select any of the following that apply to the patient:		
☐ Disease is newly diagnosed in the chronic phase		
☐ Disease is in chronic, accelerated, or lymphoid blast☐ None of the above	phase with resistance or intoleran	ce to prior therapy



EOC ID:

Sprycel-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the requested medication prescribed by, or in consu	ıltation with, an oncologist?
☐ Yes ☐ No	
Prescriber Signature	Date



EOC ID:

Stelara-12 Medicare

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

Patient Name:	Pres	scriber Name:	
Member/Subscriber Number:	Fax:	:: Phone:	
Date of Birth:	Offic	ce Contact:	
Group Number:	NPI:	: State Lic ID:	
Address:	Addı	Iress:	
City, State ZIP:	City,	, State ZIP:	
Primary Phone:	Spec	ecialty/facility name (if applicable):	
*Please note that Elixir will pro	ocess the request as written, in	ncluding drug name, with no substitution	n.
	1	☐ Expedited/Urgent	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent n	nedical history or information for the following question	this patient that may support approval. Pleas	se answer the
	<u> </u>		
Q1. Is this request for initial or	continuing therapy?		
☐ Initial therapy	☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THE	RAPY, please provide the start da	ate (MM/YY):	
Q3. Please indicate the patient	's diagnosis for the requested me	edication:	
☐ Crohn's disease, moderate	ely to severely active		
☐ Plaque psoriasis, moderate	e to severe		
☐ Psoriatic arthritis, active			
☐ Ulcerative colitis, moderate to severely active			
Other			
Q4. If the patient's diagnosis	s is OTHER, please specify below	v.	
Q5. Has the patient tried and fathat apply)?	ailed (or has a contraindication or	r intolerance to) any of the following (please	e select all
☐ Enbrel	☐ Humira	☐ None of the above	:
·	ried any of the medications listed (i.e., contraindication, history of a	in the previous question, is there a reason adverse event, etc.)?	ı why these



EOC ID:

Stelara-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the requested medication prescribed by (or in consult Rheumatologist Gastroenterologist Dermatologist None of the above	ultation with) any of the following?
Prescriber Signature	



EOC ID:

Stivarga-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the request as written	en, including drug name	e, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may estions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ару
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the request	ed medication below:	
☐ Colorectal cancer, metastatic		
☐ Gastrointestinal stromal tumor (GIST), locally advanced, unresectable or metastatic		
Liver carcinoma		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. For COLORECTAL CANCER, is the patient KRAS mu	utation-negative?	
☐ Yes	☐ No	
Q6. For COLORECTAL CANCER, has the patient been previously treated with any of the following (please select all that apply)?		
☐ Fluoropyrimidine-, oxaliplatin-, and irinotecan-based	l chemotherapy	
Anti-VEGF bevacizumab (Avastin)		
☐ Anti-EGFR panitumumab (Vectibix) or cetuximab (E	rbitux)	



EOC ID:

Stivarga-12 Medicare

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

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

Patient Name:	Prescriber Name:		
☐ None of the above			
Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?			
Q8. For GASTROINTESTINAL STROMAL TUMORS, has (please select all that apply)?	as the patient been previously treated with any of the following		
☐ Imatinib (Gleevec) ☐ Sunitinib	(Sutent)		
Q9. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?			
Q10. For LIVER CARCINOMA, has the patient been pre	eviously treated with sorafenib (Nexavar)?		
☐ Yes	□ No		
Q11. If the patient has NOT tried sorafenib (Nexavar), is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?			
Q12. Is the patient 18 years of age or older?			
☐ Yes	□ No		
Prescriber Signature	 Date		



EOC ID:

Sunosi-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicab	le):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D'		
Directions / SIG:		
Please attach any pertinent medical history or information	for this nationt that may sunnor	t annroyal Please answer the
	estions and sign.	t upprovail i lease allswer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the si	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Narcolepsy with excessive daytime drowsiness		
☐ Obstructive sleep apnea (OSA) with excessive dayti	me sleepiness	
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow:	
Q4. If the patient's diagnosis is OTTIEN, please specify	below.	
Q5. Does the patient have trial of/or contraindication to any	y of the following? (Please selec	t all that apply.)
☐ Armodafinil ☐ Modafinil	□ No	ne of the above
Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?		
Q7. Is the patient 18 years old or older?		
☐ Yes	□ No	



EOC ID:

Sunosi-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Does the patient have any of the following? (Please se	elect all that apply.)
 ☐ Concomitant use of a monoamine oxidase inhibitor (MAOI) ☐ Use within 14 days of discontinuing a monoamine oxidase inhibitor (MAOI) ☐ None of the above 	
Prescriber Signature	Date



EOC ID:

Sutent-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Initial therapy ☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Gastrointestinal stromal tumor		
☐ Pancreatic neuroendocrine tumors, unresectable local	ly advanced or metastatic	
☐ Renal cell carcinoma		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. For GASTROINTESTINAL STROMAL TUMOR, has the imatinib (Gleevec)?	ne patient had disease progression	on or intolerance to
☐ Yes	□No	
Q6. If the patient has NOT tried imatinib (Gleevec), is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?		
Q7. For RENAL CELL CARCINOMA, please select all that apply to the patient:		



EOC ID:

Sutent-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ The disease is advanced ☐ The requested medication will be used as adjuvant t for recurrence ☐ None of the above	therapy following nephrectomy in a patient who is at high risk
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Sylatron-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as v	written, including drug na	ame, with no substitution.
	☐ Expedited/Ur	rgent
Drug Name and Strength:	·	
Directions / SIG:		
Please attach any pertinent medical history or inform followin	nation for this patient that m	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide t	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	uested medication:	
☐ Melanoma with microscopic or gross nodal involvement	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Will the requested medication be used as adjuvar including complete lymphadenectomy?	nt treatment within 84 days	of definitive surgical resection,
☐ Yes	☐ No	
Q6. Does the patient have any of the following (please	e select all that apply)?	
☐ Autoimmune hepatitis		
☐ Hepatic decompensation (Child-Pugh score gre☐ None of the above	eater than 6 [Class B or C])	



EOC ID:

Sylatron-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Symdeko-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):	
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	approval. Please answer the	
	· ·		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed 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 the patier	nt:		
☐ Patient is homozygous for the F508del mutation			
Patient has at least one mutation in the cystic fibros	sis transmembrane conductance r	egulator (CFTR) gene that	
is responsive to tezacaftor/ivacaftor verified by a FDA-cle		againte (ar 117, gaine mai	
☐ None of the above			
Q6. Is the patient 6 years of age or older?			
	□ Na		
Yes	□ No		
Q7. Is the requested medication prescribed by, or in consu	ultation with, a pulmonologist?		
☐ Yes	□ No		



EOC ID:

Symdeko-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Symlin-11 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / GIG.		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Diabetes mellitus (type 1 or type 2)	☐ Other	
Q4. If the patient's diagnosis is OTHER please specify b	pelow:	
Q5. Does the patient use mealtime insulin therapy and has	s failed to achieve desired glucose	control?
Yes	□ No	
	NO	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Does the patient have any of the following (please sele	ect all that apply)?	
☐ Confirmed diagnosis of gastroparesis		
☐ Hypoglycemia unawareness		
☐ None of the above		



EOC ID:

Symlin-11 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Tabrecta-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writ	ten, including drug nar	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that ma uestions and sign.	y support approval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Does the patient have tumors with a mutation that lea	ads to mesenchymal-epi	thelial transition (MET) exon 14
skipping as detected by a FDA-approved test?		
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by or in cons	ultation with an oncologis	st?
☐ Yes	☐ No	



EOC ID:

Tabrecta-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Tafinlar-12 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable)	:	
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.			
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:		
☐ Anaplastic thyroid cancer, locally advanced or metasta	itic		
☐ Malignant melanoma, unresectable or metastatic			
Non-small cell lung cancer, metastatic			
Other			
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. For ANAPLASTIC THYROID CARCINOMA, please se	elect all that apply to the patient:		
☐ Patient has BRAF V600E mutation			
☐ The requested medication will be used in combination with trametinib (Mekinist)			
Patient has no satisfactory locoregional treatment options			
☐ None of the above			
Q6. For MELANOMA, please select all that apply to the pa	itient:		
☐ Patient has BRAF V600E or V600K mutation			



EOC ID:

Tafinlar-12 Medicare

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

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

Patient Name:	Prescriber Name:
☐ The requested medication will be used as monother ☐ The requested medication will be used in combination ☐ The requested medication will be used as adjuvant to node involvement ☐ None of the above	. ,
Q7. For NON-SMALL CELL LUNG CANCER, please select Patient has BRAF V600E mutation The requested medication will be used in combination Patient was previously treated as monotherapy None of the above	
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q9. Is the requested medication prescribed by, or in consu	lltation with, an oncologist?
☐ Yes	□ No
Prescriber Signature	 Date



EOC ID:

Tagrisso-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	i:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
<u> </u>	<u>-</u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. Please select all that apply to the patient:		
☐ The patient's diagnosis was confirmed by a FDA-approved test		
☐ The patient has EGFR exon 19 deletion or exon 21 L858R mutation		
☐ The requested medication is being used as first-line therapy		
☐ There is confirmed presence of T790M EGFR mutation		
☐ The patient's disease has progressed on or after EG☐ None of the above	FR tyroskine kinase inhibitor-base	d therapy
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	



EOC ID:

Tagrisso-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the requested medication prescribed by, or in consu	ultation with, an oncologist?
☐ Yes ☐ No	
Prescriber Signature	 Date



EOC ID:

Takhzyro-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writt	en, including drug na	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	n for this patient that m	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Hereditary angioedema	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify be	elow:	
Q5. Is the requested medication being used for the prever	ntion of attacks?	
☐ Yes	☐ No	
Q6. Is the patient 12 years of age or older?		
☐ Yes	☐ No	
Prescriber Signature		Date



EOC ID:

Takhzyro-12 Medicare

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

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

Patient Name:	Prescriber Name:

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EOC ID:

Talzenna-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Breast cancer, locally advanced or metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
Q5. Does the patient have deleterious or suspected delete	rious germline BRCA-mutation (gl	BRCAm)?
☐ Yes	□ No	
Q6. Is the patient's disease human epidermal growth facto	r receptor 2 (HER2)-negative?	
☐ Yes	□ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q8. Is the requested medication prescribed by, or in consu	Itation with, an oncologist?	
☐ Yes	□ No	



EOC ID:

Talzenna-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Targretin Gel-12 Medicare

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

Patient Name:	Prescriber Name:	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	ole):
*Please note that Elixir will process the request as written	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	i for this patient that may suppor estions and sign.	t approval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please indicate the s	start date (MM/YY):	
	, ,	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Primary cutaneous T-cell lymphoma (CTCL Stage	_	
1A/1B)	∐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	pelow.	
Q4. If the patient's diagnosis is OTTLEN, please specify	below.	
Q5. Has the patient had an inadequate response, is intoler systemic therapy (e.g., corticosteroids) indicated for cutan-		to at least one prior
☐ Yes	□ No	
Q6. If the patient has NOT tried any systemic therapies,	is there a reason why these me	edications cannot be used (i.e.,
contraindication, history of adverse event, etc.)?		
Q7. Is the requested medication being prescribed by or in	consultation with an oncologist of	or dermatologist?
☐ Yes	□ No	



EOC ID:

Targretin Gel-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Tasigna-12 Medicare

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

Patient Name:	Prescriber Name:	
		Dhanai
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
Group Number:	NPI:	State Lic ID:
Address:	Address:	Otate Elo ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	□ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		pproval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML)	☐ Other	
, , , , , , , , , , , , , , , , , , ,	h a lavu	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select all that apply to the patient:		
☐ The disease is in accelerated phase		
☐ The disease is in chronic phase		
☐ The patient is newly diagnosed		
☐ The patient is resistant or intolerant to prior therapy	that included imatinib (Gleevec)	
☐ The patient is resistant or intolerant to prior tyrosine	kinase inhibitor therapy	
☐ None of the above		
Q6. Is the requested medication prescribed by, or in consu	ultation with, an oncologist?	
☐ Yes	□ No	



EOC ID:

Tasigna-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Does the patient have any of the following (please sele	ect all that apply)?
☐ Long QT syndrome	
☐ Uncorrected hypokalemia	
☐ Uncorrected hypomagnesemia	
☐ Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors	
☐ None of the above	
Prescriber Signature	Date



EOC ID:

Tazverik-12 Medicare

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

	1	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	ipplicable):
*Please note that Elixir will process the request as writte	en, including drug name	e, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may s estions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Epithelioid sarcoma, metastatic or locally advanced		
Follicular lymphoma, relapsed or refractory		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For EPITHELIOID SARCOMA, is the patient eligible for	or complete resection?	
☐ Yes	☐ No	
Q6. For FOLLICULAR LYMPHOMA, please select all that	apply to the patient:	
☐ The patient has tumors that are positive for an EZH.		a FDA-approved test
☐ The patient has received at least 2 prior systemic th	•	
☐ The patient has no satisfactory alternative treatment	•	
☐ None of the above	•	



EOC ID:

Tazverik-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the requested medication prescribed by (or in consu	ıltation with) an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Tegsedi-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility na	ame (if applicable):
*Please note that Elixir will process the request as writte	en, including drug	g name, with no substitution.
	☐ Expedite	d/Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient thatestions and sign.	at may support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuin	g therapy
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
Polyneuropathy of hereditary transthyretin-mediated amyloidosis	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify I	below:	
Q5. Is the patient 18 years of age or older?		
	□ Na	
Yes	☐ No	
Q6. Does the patient have any of the following (please sele	ect all that apply)?	
☐ Platelet count less than 100,000 per microliter		
☐ Urinary protein to creatinine ratio (UPCR) of 1000 m ☐ None of the above	g/g or higher	
Prescriber Signature		Date



EOC ID:

Tegsedi-13 Medicare

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

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

Patient Name:	Prescriber Name:



EOC ID:

Testosterone-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicate	ole):
*Please note that Elixir will process the request as writte	en, including drug name, with	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
T		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may supporestions and sign.	t approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Hypogonadism, hypogonadotropic or primary		
☐ Inoperable metastatic breast cancer		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify l	pelow:	
Q5. For BREAST CANCER, is the patient postmenopausa	l?	
☐ Yes ☐ No	□ No	t applicable
Q6. For HYPOGONADISM, has the diagnosis been confirm defined by the normal laboratory reference value?	ned by a low-for-age serum tes	tosterone (total or free) level
☐ Yes	□ No	
Q7. Does the patient have any of the following (please sele	ect all that apply)?	



EOC ID:

Testosterone-12 Medicare

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

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

Patient Name:	Prescriber Name:	
☐ Pregnancy ☐ None of the above		
Prescriber Signature	 Date	



FOC ID

Tetrabenazine-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as writ	tten, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or information following q	on for this patient that muestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Chorea associated with Huntington's disease	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Does the patient have any of the following (please se	elect all that apply)?	
☐ Be actively suicidal		
☐ Untreated or inadequately treated depression		
☐ Impaired hepatic function		
☐ Concomitant use of monoamine oxidase inhibitors		
☐ Concomitant use of reserpine or within 20 days of	discontinuing reserpine	2
☐ None of the above		
Prescriber Signature		Date



FOC ID:

Tetrabenazine-12 Medicare

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

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

Patient Name:	Prescriber Name:



EOC ID:

Thalomid-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:		Phone:
Date of Birth:	Fax: Office Contact:	FIIONE.
Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lie ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Elixir will process the red		
	Expedited/Urge	
Drug Name and Strength:	_ Expedited/Orge	
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy	☐ Continuing ther	тару
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis f	or the requested medication:	
☐ Multiple myeloma, newly diagnosed	·	
☐ Erythema nodosum leprosum (ENL)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, μ	please specify below:	
Q5. Is the requested medication prescribed	by, or in consultation with, an oncologi	ist or infectious disease specialist?
☐ Yes	□ No	
Q6. Is the patient pregnant?		
Yes		
☐ Not applicable - the patient is not of child	d-bearing potential	



EOC ID:

Thalomid-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Tibsovo-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Acute myeloid leukemia	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select all that apply to the patient:		
☐ The disease is relapsed or refractory		
☐ The patient is newly diagnosed		
☐ The patient has susceptible isocitrate dehydrogenas	e-1 mutation	
☐ The patient is 75 years of age or older		
The patient has comorbidities that preclude intensive	e induction chemotherapy	
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
	□	



EOC ID:

Tibsovo-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?	
☐ Yes ☐ No	
Prescriber Signature	Date



EOC ID:

Trelegy-15 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as written	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please indicate Start	t Date:	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
	Other	
Chronic Obstructive Pulmonary Disease (COPD)		
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. Does the patient have a history of failure, contraindica alternatives?	ition, or intolerance to any of the fo	ollowing formulary
☐ Advair Diskus		
☐ Anoro Ellipta		
☐ Breo Ellipta		
☐ Fluticasone/Salmeterol		
Serevent Diskus		
Spiriva HandiHaler		
☐ Spiriva Respimat ☐ None of the above		
☐ NOTIC OF THE ADOVE		



EOC ID:

Trelegy-15 Medicare

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

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

Patient Name:	Prescriber Name:
Q6. If the patient has NOT tried any of the above medications, is there a reason these medications cannot be u (i.e. contraindication, history of adverse event, etc)?	
Prescriber Signature	Date



EOC ID:

Trikafta-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Cystic fibrosis	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have at least 1 F508del mutation in to (CFTR) gene verified by an FDA-cleared CF mutation test		conductance regulator
☐ Yes	□ No	
Q6. Is the patient 12 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by (or in const	ultation with) any of the following?	
☐ Prescriber from a CF center accredited by the Cystic ☐ Pulmonologist ☐ None of the above	c Fibrosis Foundation	
☐ Pulmonologist ☐ None of the above		



EOC ID:

Trikafta-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Tukysa-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	Ciale Elo IB.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Elixir will process the request as writte	en, including drug na	ame, with no substitution.
	☐ Expedited/Ur	
Drug Name and Strength:	·	
Directions / SIG:		
Please attach any pertinent medical history or information	ı for this patient that m	ay support approval. Please answer the
	ostions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide the st	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Breast cancer, advanced unresectable or metastatic (including brain metastases)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select all that apply to the patient:		
☐ The patient's disease is human epidermal growth fac	ctor receptor 2 (HER2)-positive
☐ The requested medication will be used in combination	on with trastuzumab a	nd capecitabine
☐ The patient has received one or more prior anti-HEF☐ None of the above	R2 based regimens in	the metastatic setting
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q7. Is the requested medication prescribed by (or in consu	ultation with) an oncolo	ogist?



EOC ID:

Tukysa-12 Medicare

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

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



EOC ID:

Turalio-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	e):
*Please note that Elixir will process the request as writte	en, including drug name, with r	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / Gro.		
Please attach any pertinent medical history or information following qu	n for this patient that may support estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Tenosynovial giant cell tumor (TGCT)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select all that apply to the patient:		
☐ The patient is symptomatic		
☐ The patient's disease is associated with severe mor	bidity or functional limitations	
☐ The patient's disease is not amenable to improveme	•	
☐ None of the above		
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q7. Is the requested medication prescribed by, or in consu		
☐ Yes	□ No	



EOC ID:

Turalio-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Tymlos-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	olicable):
*Please note that Elixir will process the request as writte	en, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Places attach any partinent modical history or information	a for this notion that may au	nnort annroyal. Places answer the
Please attach any pertinent medical history or information following qu	estions and sign.	pport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	1
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Postmenopausal osteoporosis	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Has the patient had an osteoporotic fracture or has mo	ultiple risk factors for fractur	re?
☐ Yes	☐ No	
Q6. Has the patient had previous trial and failure, contrainall that apply)?	dication, or intolerance to a	ny of the following (please select
☐ Bisphosphonate ☐ Prolia		None of the above
Q7. If the patient has NOT tried any of the medications medications cannot be used (i.e., contraindication, histo		on, is there a reason why these



EOC ID:

Tymlos-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 treatment duration exceeded 24 months during th	e patient's lifetime?
☐ Yes	□ No
Prescriber Signature	Date



EOC ID:

Uptravi-13 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Pulmonary arterial hypertension (PAH), World Health Organization (WHO) Group 1	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Has the patient's diagnosis been confirmed by right he	eart catheterization?	
☐ Yes	□No	
Q6. Has the patient tried and had an insufficient response	to at least one other PAH agent th	erapy (e.g., sildenafil)?
☐ Yes	□ No	
Q7. If the patient has NOT tried any PAH agents, is ther contraindication, history of adverse event, etc.)?	e a reason why these medications	cannot be used (i.e.,
Q8. Is the patient 18 years of age or older?		



EOC ID:

Uptravi-13 Medicare

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

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

Patient Name:	Prescriber Name:	
☐ Yes	□No	
Prescriber Signature	e Da	ite



EOC ID:

Venclexta-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	e):
*Please note that Elixir will process the request as writte	en, including drug name, with r	no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please indicate the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Acute myeloid leukemia (AML), newly diagnosed		
☐ Chronic lymphocytic leukemia (CLL)		
☐ Small lymphocytic lymphoma (SLL)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For ACUTE MYELOID LEUKEMIA, please select all the	nat apply to the patient:	
☐ The patient is 75 years of age or older		
☐ The patient has comorbidities that preclude the use	of intensive induction chemother	ару
☐ The requested medication will be used in combination. ☐ None of the above	on with azacitidine, decitabine or	low-dose cytarabine
Q6. Is the patient 18 years of age or older?		
y Yes	□ No	



EOC ID:

Venclexta-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q7. Is the requested medication prescribed by, or in consu	Itation with, an oncologist?
☐ Yes	□ No
Q8. For CHRONIC LYMPHOCYTIC LEUKEMIA OR SMAL CYP3A inhibitor concomitantly during the initial and titration	L LYMPHOCYTIC LEUKEMIA, will the patient use a strong phase?
☐ Yes	□ No
Prescriber Signature	



EOC ID:

Verzenio-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if ap	pplicable):
*Please note that Elixir will process the request as writte	en, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may su	upport approval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	V.
		у
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Breast cancer, advanced or metastatic	☐ Other	
OA KU U U U U OTUED I U		
Q4. If the patient's diagnosis is OTHER, please specify	pelow:	
Q5. Please select all that apply to the patient:		
☐ The patient's disease is hormone receptor (HR)-pos	itive	
The patient's disease is human epidermal growth fac		
☐ The requested medication is being used in combinat	tion with fulvestrant for the	treatment of disease progression
following endocrine therapy		
☐ The requested medication is being used as monother endocrine therapy	erapy for the treatment of 0	ilsease progression following
☐ The requested medication is being used as initial en	docrine-based treatment in	n combination with an aromatase
inhibitor	and a second a continent in	The state of the s
☐ None of the above		



EOC ID:

Verzenio-12 Medicare

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

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

Patient Name:	Prescriber Name:	
Q6. What is the patient's menopause status?		
☐ Postmenopausal		
☐ Premenopausal or perimenopausal		
☐ None of the above		
Q7. Has the patient had trial and failure or contrain	ndication to any of the following (please select all that	apply)?
☐ Ibrance ☐ Kis	qali	ve
Q8. If the patient has NOT tried any of the med medications cannot be used (i.e., contraindicati	ications listed in the previous question, is there a reas on, history of adverse event, etc.)?	on why these
Q9. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q10. Is the requested medication prescribed by, o	r in consultation with, an oncologist?	
☐ Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Vitrakvi-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
*Please note that Elixir will process the req	uest as written, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history		ay support approval. Please answer the
	following questions and sign.	
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	or the requested medication:	
Q3. Please indicate the patient's diagnosis fo	or the requested medication:	
	☐ Other	
☐ Solid tumors	Other	
☐ Solid tumors Q4. If the patient's diagnosis is OTHER, p	Other	
☐ Solid tumors Q4. If the patient's diagnosis is OTHER, p Q5. Please select all that apply to the patient	Other lease specify below: :: surgically unresectable	e fusion-positive
☐ Solid tumors Q4. If the patient's diagnosis is OTHER, p Q5. Please select all that apply to the patient ☐ The patient's disease is metastatic or	Other lease specify below: :: surgically unresectable receptor tyrosine kinase (NTRK) generally	•
☐ Solid tumors Q4. If the patient's diagnosis is OTHER, p Q5. Please select all that apply to the patient ☐ The patient's disease is metastatic or compared in the patient's disease is neurotrophic record in the patient has unsatisfactory alternative.	Other lease specify below: :: surgically unresectable ecceptor tyrosine kinase (NTRK) generative treatments or has progressed follows:	lowing treatment



EOC ID:

Vitrakvi-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Vizimpro-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (f applicable):
*Please note that Elixir will process the request as writ	ten, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that ma uestions and sign.	y support approval. Please answer the
Г		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Does the patient have confirmed epidermal growth fa		on 19 deletion or exon 21 L858R
substitution mutations as detected by a FDA-approved te	st?	
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by, or in cons	sultation with, an oncolog	ist?
☐ Yes	☐ No	



EOC ID:

Vizimpro-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Vyndamax-14 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as writte	en, including drug n	ame, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that mestions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Transthyretin related familial amyloid cardiomyopath (wild type or hereditary)	y ☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Is the requested medication prescribed by (or in const	ultation with) a cardiol	ogist?
☐ Yes	☐ No	
Prescriber Signature	<u></u>	Date



EOC ID:

Vyndamax-14 Medicare

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

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

Patient Name:	Prescriber Name:	



EOC ID:

Xalkori-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the request as writ	ten, including drug nam	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that may uestions and sign.	support approval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial Therapy	☐ Continuing The	rapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Is the patient's disease anaplastic lymphoma kinase	(ALK)-positive or ROS1-p	positive as detected by a FDA-
approved test?		
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q7. Is the requested medication prescribed by, or in cons	sultation with, an oncologi	st?
☐ Yes	☐ No	
	—	



EOC ID:

Xalkori-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	 Date



EOC ID:

Xeljanz-14 Medicare

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

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Elixir will process the request as wi	ritten, including drug n	ame, with no substitution.
	☐ Expedited/U	Irgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following	tion for this patient that r questions and sign.	nay support approval. Please answer the
<u> </u>		
O4. In this request for initial or continuing thereous?		
Q1. Is this request for initial or continuing therapy?	_	
☐ Initial therapy	☐ Continuing t	herapy
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Psoriatic arthritis, active		
☐ Rheumatoid arthritis, moderate to severe		
☐ Ulcerative colitis, moderate to severe		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please spec	ify below.	
Q4. If the patient o diagnosis is officer, piease spee	my below.	
Prescriber Signature		Date



EOC ID:

Xgeva-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	e):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that may support a estions and sign.	approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Bone metastases from a solid tumor		
Giant cell tumor of the bone		
☐ Hypercalcemia of malignancy		
☐ Prevention of skeletal-related events associated with n	nultiple myeloma	
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. For GIANT CELL TUMOR OF THE BONE, is the patient's disease unresectable or surgical resection is likely to result in severe morbidity?		
☐ Yes	□ No	
Q6. For HYPERCALCEMIA OF MALIGNANCY, is the patient's disease refractory to bisphosphonate therapy?		
□ No		



EOC ID:

Xgeva-12 Medicare

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

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

Patient Name:	Prescriber Name:	
☐ Not applicable - the patient has not tried bisphosphonates		
Q7. If the patient has NOT tried bisphosphonate therapy (i.e., contraindication, history of adverse event, etc.)?	, is there a reason why these medications cannot be used	
Q8. Does the patient have hypocalcemia (calcium less than 8.0 mg/dL)?		
☐ Yes	□ No	
Prescriber Signature		



EOC ID:

Xolair-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	licable):
*Please note that Elixir will process the request as writte	en, including drug name, v	vith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may sup estions and sign.	port approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Initial therapy ☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Chronic idiopathic urticaria		
☐ Moderate to severe persistent asthma		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. For URTICARIA, does the patient remain symptomatic	despite H1 antihistamine th	nerapy?
☐Yes		
□No		
☐ Not applicable - the patient has not tried H1 antihistamine therapy		
Q6. If the patient has NOT tried H1 antihistamine therapy, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?		
Q7. For ASTHMA, please select all that apply to the patier	nt:	



EOC ID:

Xolair-12 Medicare

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

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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 positive skin test or in vitro reactivity to a perennial aeroallergen ☐ The patient's symptoms are inadequately controlled with inhaled corticosteroids ☐ None of the above		
Q8. Is the patient 6 years of age or older?		
Yes	□ No	
Q9. Is the requested medication prescribed by, or in consultation with, an allergist, immunologist, pulmonologist, or dermatologist?		
Yes	□ No	
Prescriber Signature	 Date	



EOC ID:

Xospata-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Elixir will process the request as wi	itten, including drug na	me, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Birodione / Gre.		
Please attach any pertinent medical history or information		y support approval. Please answer the
following	questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/VV):	
Q2. FOR CONTINUING THE NAME I, please provide the	e start date (wilvi/ 1 1).	
	ested medication:	
Q3. Please indicate the patient's diagnosis for the reque		
	ested medication:	
Q3. Please indicate the patient's diagnosis for the reque	☐ Other	
Q3. Please indicate the patient's diagnosis for the reque	☐ Other	
Q3. Please indicate the patient's diagnosis for the reque	Other	oproved test?
Q3. Please indicate the patient's diagnosis for the requestion Acute myeloid leukemia, relapsed or refractory Q4. If the patient's diagnosis is OTHER, please spec	Other	oproved test?
Q3. Please indicate the patient's diagnosis for the requestion. Acute myeloid leukemia, relapsed or refractory. Q4. If the patient's diagnosis is OTHER, please specting. Q5. Does the patient have a presence of FLT3 mutation. Yes	☐ Other Ify below: a as detected by a FDA-ap	oproved test?
Q3. Please indicate the patient's diagnosis for the reques Acute myeloid leukemia, relapsed or refractory Q4. If the patient's diagnosis is OTHER, please spec Q5. Does the patient have a presence of FLT3 mutation Yes Q6. Is the patient 18 years of age or older?	☐ Other ify below: as detected by a FDA-ap ☐ No	oproved test?
Q3. Please indicate the patient's diagnosis for the requestion. Acute myeloid leukemia, relapsed or refractory. Q4. If the patient's diagnosis is OTHER, please specting. Q5. Does the patient have a presence of FLT3 mutation. Yes	☐ Other Ify below: a as detected by a FDA-ap	oproved test?
Q3. Please indicate the patient's diagnosis for the reques Acute myeloid leukemia, relapsed or refractory Q4. If the patient's diagnosis is OTHER, please spect Q5. Does the patient have a presence of FLT3 mutation Yes Q6. Is the patient 18 years of age or older?	☐ Other Ify below: as detected by a FDA-ap ☐ No ☐ No	



EOC ID:

Xospata-12 Medicare

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

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Xpovio-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the request as writte	en, including drug name, with n	o substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:	
☐ Diffuse large B-cell lymphoma, relapsed or refractory (DLBCL, including from follicular lymphoma)		
☐ Multiple myeloma, relapsed or refractory ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For DIFFUSE LARGE B-CELL LYMPHOMA, has the page 100 per page 100 p	patient received at least 2 lines of	systemic therapy?
☐ Yes	□ No	
Q6. For MULTIPLE MYELOMA, will the requested medica	tion be used in combination with d	examethasone?
☐ Yes	□ No	
Q7. For MULTIPLE MYELOMA, has the patient received a	at least 4 prior therapies?	
☐ Yes	□ No	



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Patient Name:	Prescriber Name:		
Q8. For MULTIPLE MYELOMA, is the patient's disease refractory to any of the following? (Please select all that			
apply.)			
☐ At least two proteasome inhibitors			
☐ At least two immunomodulatory agents			
☐ An anti-CD38 monoclonal antibody			
☐ None of the above			
Q9. If the patient has NOT tried any of the medications listed medications cannot be used (i.e., contraindication, history of the medication of the medicati	, , , , ,		
Q10. Is the patient 18 years of age or older?			
☐Yes	□ No		
Q11. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?			
☐Yes	□ No		
Prescriber Signature			



EOC ID:

Xtandi-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Elixir will process the re	equest as written, including drug nar	me, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	ry or information for this patient that ma following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing the	nerany?	
		rany
☐ Initial therapy	Continuing the	нару
Q2. For CONTINUING THERAPY, pleas	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Prostate cancer (castration-resistant)		
☐ Prostate cancer (metastatic, castration	-sensitive)	
☐ Other		
Q4. If the patient's diagnosis is OTHER,	please specify below:	
Q5. Is the patient 18 years of age or older?	,	
☐ Yes	□No	
Q6. Is the requested medication prescribed	by (or in consultation with) an oncolog	gist or urologist?
Yes	□No	-
Prescriber Signature		Date



EOC ID:

Xtandi-12 Medicare

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

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Deficut News	Dura suite su Names
Patient Name:	Prescriber Name:



EOC ID:

Xuriden-12 Medicare

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Elixir will process the red	quest as written, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	y or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis f	for the requested medication:	
☐ Hereditary orotic aciduria	☐ Other	
Q4. If the patient's diagnosis is OTHER, μ	please specify below:	
Prescriber Signature		Date



EOC ID:

Xyrem-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	if applicable):
*Please note that Elixir will process the requ	est as written, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history of	or information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing there	ару?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please s	specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	the requested medication:	
☐ Narcolepsy with cataplexy	·	
☐ Narcolepsy with excessive daytime slee	epiness	
Q4. If the patient's diagnosis is OTHER, ple	ease specify below:	
Q5. Is the patient 7 years of age or older?		
∏Yes	□No	
Q6. Does the patient have any of the following	g (please select all that apply)?	
_		
Q6. Does the patient have any of the following	pnotic agents	



EOC ID:

Xyrem-12 Medicare

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Patient Name:	Prescriber Name:
Prescriber Signature	Date



EOC ID:

Yonsa-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Elixir will process the request as writ	ten, including drug nar	ne, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Direction of Green		
Please attach any pertinent medical history or information	on for this patient that may	y support approval. Please answer the
	uestions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication below:	
☐ Prostate cancer (metastatic, castration-resistant)	☐ Other	
<u> </u>		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the requested medication being used in combination	on with methylprednisolo	ne?
☐ Yes	☐ No	
		
Q6. Does the patient have documented history of trial with contraindication to Zytiga (abiraterone)?	n, inadequate treatment	response, adverse event, or
☐ Yes	□No	
Q7. If the patient has NOT tried Zytiga (abiraterone), is	there a reason why this	medication cannot be used (i.e.
contraindication, history of adverse event, etc.)?	mere a reason willy tills	medication cannot be used (i.e.,
22aa.a.a.a.,a.a.y 31 davoido ovoiti, oto.y.		



EOC ID:

Yonsa-12 Medicare

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

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

Patient Name:	Prescriber Name:
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q9. Is the requested medication prescribed by, or in consu	Itation with, an oncologist?
☐ Yes	□ No
Q10. Please select all that apply to the patient:	
☐ The patient's partner is pregnant	
☐ The patient has severe baseline hepatic impairment	(Child-Pugh Class C)
☐ None of the above	
Prescriber Signature	



EOC ID:

Zarxio-12 Medicare

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility nam	ne (if applicable):
*Please note that Elixir will process the request as writt	ten, including drug	name, with no substitution.
	☐ Expedited/	Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	on for this patient that uestions and sign.	may support approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing	therapy
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ted medication:	
Autologus peripheral-blood progenitor cell transplant t	to mobilize progenitor	cells for collection by leukapheresis
Chemotherapy-induced febrile neutropenia, prophylax		
Hematopoietic subsyndrome of acute radiation syndrome	ome (H-ARS)	
│		
Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
December Circumstrum		Data
Prescriber Signature		Date



EOC ID:

Zejula-12 Medicare

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

Patient Name:	Prescriber Name:			
Member/Subscriber Number:	Fax:	Phone:		
Date of Birth:	Office Contact:			
Group Number:	NPI:	State Lic ID:		
Address:	Address:			
City, State ZIP:	City, State ZIP:			
Primary Phone:	Specialty/facility name (if applicable):			
*Please note that Elixir will process the request as written, including drug name, with no substitution.				
	☐ Expedited/Urgent			
Drug Name and Strength:				
Directions / SIG:				
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.				
Q1. Is this request for initial or continuing therapy?				
☐ Initial therapy	☐ Continuing therapy			
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):				
Q3. Please indicate the patient's diagnosis for the requeste	ed medication:			
☐ Advanced or recurrent epithelial ovarian cancer, rec	urrent fallopian tube cancer, or rec	urrent primary peritoneal		
cancer				
☐ Advanced ovarian, fallopian tube, or primary peritoneal cancer☐ Other				
Q4. For ADVANCED OR RECURRENT EPITHELIAL OVARIAN CANCER, RECURRENT FALLOPIAN TUBE				
CANCER, OR RECURRENT PRIMARY PERITONEAL CANCER, please select all that apply to this patient:				
☐ The requested medication will be used as maintenance therapy				
☐ The patient is in a complete or partial response to☐ None of the above	o platinum-based chemotherapy (e	.g., cisplatin, carboplatin)		
Q5. For ADVANCED OVARIAN, FALLOPIAN TUBE, OF apply to this patient:	R PRIMARY PERITONEAL CANCE	ER, please select all that		
☐ The patient has been treated with 3 or more prior	r chemotherapy regimens			
☐ The patient's cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA mutation, or genomic instability				



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Zejula-12 Medicare

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Patient Name:	Prescriber Name:		
☐ The patient's disease has progressed more than chemotherapy ☐ None of the above	6 months after response to the last platinum-based		
Q6. If the patient's diagnosis is OTHER, please specify l	pelow:		
Q7. Is the patient 18 years of age or older?			
☐ Yes	□ No		
Q8. Is the requested medication prescribed by (or in consultation with) an oncologist or gynecologist?			
☐ Yes	□ No		
Prescriber Signature	Date		



EOC ID:

Zykadia-12 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	f applicable):
*Please note that Elixir will process the request as w	ritten, including drug nan	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	ation for this patient that may g questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	тару
Q2. For CONTINUING THERAPY, please provide the	ne start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	ested medication:	
Q3. Please indicate the patient's diagnosis for the required Metastatic non-small cell lung cancer (NSCLC)	uested medication:	
<u> </u>	☐ Other	
☐ Metastatic non-small cell lung cancer (NSCLC)	☐ Other cify below:	
☐ Metastatic non-small cell lung cancer (NSCLC) Q4. If the patient's diagnosis is OTHER, please spe	☐ Other cify below:	
☐ Metastatic non-small cell lung cancer (NSCLC) Q4. If the patient's diagnosis is OTHER, please spe Q5. Is the patient's disease anaplastic lymphoma kinas	Other cify below: se (ALK)-positive?	
☐ Metastatic non-small cell lung cancer (NSCLC) Q4. If the patient's diagnosis is OTHER, please spe Q5. Is the patient's disease anaplastic lymphoma kinas	Other cify below: se (ALK)-positive?	
☐ Metastatic non-small cell lung cancer (NSCLC) Q4. If the patient's diagnosis is OTHER, please spe Q5. Is the patient's disease anaplastic lymphoma kinas ☐ Yes Q6. Is the patient 18 years of age or older?	☐ Other cify below: se (ALK)-positive? ☐ No ☐ No	ist?



EOC ID:

Zykadia-12 Medicare

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



EOC ID:

Zytiga-12 Medicare

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Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Elixir will process the req	quest as written, including drug nam	ne, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis f	or the requested medication:	
☐ Metastatic prostate cancer, castration-re	esistant	
☐ Metastatic prostate cancer, high-risk, ca☐ Other		
Q4. If the patient's diagnosis is OTHER, p	please specify below:	
Q5. Is the requested medication being used	combination with prednisone?	
☐ Yes	☐ No	
Prescriber Signature		Date