COVERAGE DETERMINATION REQUEST FORM

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

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

☐ Chronic granulomatous disease for use in reducing the frequency and severity of serious infections associated with chronic granulomatous disease
☐ Severe malignant osteopetrosis (SMO)
☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adempas-16 Medicare

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

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

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication: *

☐ Chronic thromboembolic pulmonary hypertension (CTEPH) WHO Group 4
☐ Pulmonary arterial hypertension (PAH) WHO Group 1
☐ Other

Q4. For CTEPH, please select if any of the following apply to this patient:

☐ The patient has persistent or recurrent disease after surgical treatment (such as pulmonary endarterectomy)
☐ The patient's condition is inoperable
☐ None of the above

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

☐ Yes ☐ No

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

Q7. For FEMALE patients, is the patient enrolled in the ADEMPAS REMS program?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Adempas-16 Medicare

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

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

Patient Name:	**Prescriber Name:**

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

Q8. Is the patient pregnant?

☐ Yes ☐ No ☐ Not Applicable

Q9. Will the patient be taking any of the following concomitantly while on the requested medication (please select all that apply)?

☐ Nitrates or nitric oxide donors (such as amyl nitrate) in any form
☐ Phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or verdenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline)
☐ None of the above

Q10. Does the patient have pulmonary hypertension associated with idiopathic interstitial pneumonia?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alecensa-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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

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

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

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

Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)- positive?
☐ Yes ☐ No

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Alecensa-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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Alpha-1 Proteinase Inhibitor-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Alpha-1 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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Alpha-1 Proteinase Inhibitor-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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alunbrig-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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other

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

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

Q6. Has the patient experienced disease progression on (or is intolerant to) crizotinib (Xalkori)?
☐ Yes ☐ No

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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Alunbrig-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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ambrisentan-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

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

Q4. If the diagnosis is OTHER, please specify.

Q5. Was the diagnosis confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q6. Please indicate if the patient has any of these exclusions:

☐ Pregnancy
☐ Idiopathic pulmonary fibrosis (IPF), including those with pulmonary hypertension
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Ambrisentan-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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Amphetamines-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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 which medication is being requested:

☐ Amphetamine-dextroamphetamine ER
☐ Dextroamphetamine ER
☐ Dextroamphetamine IR
☐ Vyvanse

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Amphetamines-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:**

☐ For Narcolepsy, the prescriber has provided justification confirming that a sleep study would not be feasible

☐ The patient will not be concomitantly using the medication with MAOIs or will not use the medication within 14 days of MAOI administration

☐ The prescriber is a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs

☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arcalyst-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ 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 below:

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Pulmonary Mycobacterium avium complex (MAC) infection ☐ Other

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

Q5. Will the requested medication be used as part of a combination antibacterial regimen in treatment of refractory patients?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by (or in consultation with) an infectious disease specialist or pulmonologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Arikayce-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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Auryxia-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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

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

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

Q4. Does the patient have chronic kidney disease (CKD)?
☐ Yes ☐ No

Q5. Is the patient on dialysis?
☐ Yes ☐ No

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

Q7. Does the patient have any iron overload syndromes (e.g., hemochromatosis)?
☐ Yes ☐ No

Q8. Is the requested medication being prescribed by, or in consultation with, a hematologist or nephrologist?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Auryxia-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

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Austedo-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Chorea associated with Huntington's disease (Huntington'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 or neurologist?

☐ Yes ☐ No

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

☐ Hepatic impairment
☐ Suicidal ideation

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Austedo-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:**

☐ Untreated or inadequately treated depression
☐ None of the above

Q8. Is the patient taking MAOIs, reserpine, or tetrabenazine?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ayvakit-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 (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 requested medication:

☐ Gastrointestinal stromal tumor, unresectable or metastatic ☐ Other

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

Q5. Is there presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations?

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Ayvakit-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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Balversa-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Urothelial carcinoma, locally advanced or metastatic ☐ Other

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ The patient has susceptible FGFR3 or FGFR2 genetic alterations

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

☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Balversa-12 Medicare

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

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

Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Pulmonary arterial hypertension (PAH) ☐ Other

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

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

☐ Right heart catheterization
☐ Doppler echocardiogram (if patient is unable to undergo a right heart catheterization [e.g., patient is frail, elderly, etc.])
☐ None of the above

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

☐ Yes ☐ No

Q7. FOR FEMALE PATIENTS OF REPRODUCTIVE POTENTIAL, has pregnancy been excluded and patient will use

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
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 accompanied by signs or symptoms of liver dysfunction or injury or bilirubin at least 2 times the upper limit of normal (ULN)?

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

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

Q4. For Ph+ CML, has the patient had resistance, relapse, or inadequate response to prior therapy with one of the following tyrosine kinase inhibitors (TKI) (please select all that apply)?

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

Q5. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, disease is resistant or intolerant, etc)?

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

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Colorectal cancer (metastatic)
☐ Melanoma (unresectable or metastatic)
☐ Other

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

Q5. Please select all that apply to the patient:

☐ 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 therapy
☐ 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?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Braftovi-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 being prescribed by or in consultation with an oncologist?	
☐ Yes	☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Brukinsa-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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Mantle cell lymphoma ☐ Other

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Brukinsa-13 Medicare

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

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Patient Name:	**Prescriber Name:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cablivi-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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Thrombotic thrombocytopenic purpura, acquired (aTTP) ☐ Other

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q7. Please indicate the Prescriber's specialty:

☐ Hematologist ☐ Oncologist ☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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Cablivi-13 Medicare

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cabometyx-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Renal cell carcinoma (advanced)
☐ Hepatocellular carcinoma (HCC) (advanced) in patients previously treated with Nexavar (sorafenib)
☐ 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 (or is at risk for) severe hemorrhage?

☐ Yes ☐ No

Q7. Does the patient have a recent history of bleeding or hemoptysis?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Calquence-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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Chronic lymphocytic leukemia
☐ Mantle cell lymphoma
☐ Small lymphocytic lymphoma
☐ Other

Q4. For MANTLE CELL LYMPHOMA, has the patient tried 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 consultation with) an oncologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Calquence-13 Medicare

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

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cayston-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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

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

Q3. Please indicate that patient's diagnosis for the requested medication:
☐ Cystic fibrosis (CF) ☐ Other

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

Q5. Has the diagnosis been confirmed by appropriate diagnostic or genetic testing?
☐ Yes ☐ No

Q6. Does the patient have evidence of P. aeruginosa in the lungs as confirmed by cultures of the airways?
☐ Yes ☐ No

Q7. Is the patient 7 years of age or older?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cayston-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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
CNS Stimulants-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

- ☐ 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 SLEEP APNEA (OSA), was the diagnosis confirmed by sleep lab evaluation?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
CNS Stimulants-12 Medicare

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

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Patient Name:	**Prescriber Name:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Copiktra-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

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

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Copiktra-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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Stable, symptomatic chronic heart failure
☐ Stable, symptomatic heart failure due to dilated cardiomyopathy
☐ Other

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

Q5. For CHRONIC HEART FAILURE, does the patient have any of the following (please select all that apply)?

☐ Left ventricular ejection fraction (LVEF) 35% or less
☐ Sinus rhythm with resting heart rate 70 beats per minute or more
☐ Taking maximally tolerated doses of beta-blockers
☐ Contraindication to beta-blocker use
☐ None of the above

Q6. For HEART FAILURE DUE TO DILATED CARDIOMYOPATHY, is the patient in sinus rhythm with an elevated heart rate?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Corlanor-12 Medicare

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

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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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Ankylosing spondylitis
☐ Non-radiographic axial spondyloarthritis
☐ Plaque psoriasis (moderate to severe)
☐ Psoriatic arthritis (active)
☐ Other

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

Q5. Has the patient tried and failed (or has a contraindication or intolerance) to any of the following (please select all that apply)?

☐ Enbrel ☐ Humira ☐ None of the above

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.)?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cosentyx-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. Has the patient been screened for latent tuberculosis infection as required prior to initiation of treatment?

☐ Yes ☐ No

Q8. Is the requested medication prescribed by (or in consultation with) any of the following?

☐ Dermatologist ☐ Rheumatologist ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Melanoma (unresectable or metastatic malignant) ☐ Other

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

Q5. Does the patient have BRAF V600E or V600K mutation?

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cotellic-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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

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

Q5. Does the patient have corneal crystal accumulation?
☐ Yes ☐ No

Q6. Does the patient have any hypersensitivity to cysteamine or penicillamine?
☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Cystaran-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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 specify the start date (MM/YY):

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

☐ Multiple sclerosis (MS) ☐ Other

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

Q5. Has patient demonstrated sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting the medication?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

COVERAGE DETERMINATION REQUEST FORM

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 clearance less than or equal to 50 mL/minute)
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Acute myeloid leukemia (newly diagnosed) ☐ Other

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

Q5. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy?

☐ Yes ☐ No

Q6. Will Daurismo be used in combination with cytarabine?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 CONTNUING THERAPY, please specify the start date (MM/YY):

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

☐ Chronic iron overload due to blood transfusions (transfusion hemosiderosis)
☐ Chronic iron overload in non-transfusion-dependent thalassemia syndromes
☐ Other

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

Q5. For CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS, please select all that apply to the patient:

☐ The patient had a transfusion of at least 100 mL/kg packed red blood cells
☐ The patient has serum ferritin level greater than 1000 mcg/L
☐ None of the above

Q6. For CHRONIC IRON OVERLOAD IN NON-TRANSFUSION-DEPENDENT THALASSEMIA SYNDROMES, please select all that apply to the patient:

☐ Patient has liver iron concentrations of at least 5 mg Fe/g dry weight
☐ Patient has serum ferritin level greater than 300 mcg/L

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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 request as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Actinic keratosis ☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

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 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 specify the start date (MM/YY):

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

☐ Anorexia associated with weight loss in a patient with AIDS
☐ Chemotherapy-induced nausea and vomiting
☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Ankylosing spondylitis
☐ Chronic plaque psoriasis, moderate to severe
☐ Polyarticular juvenile idiopathic arthritis, moderate to severe
☐ Psoriatic arthritis
☐ Rheumatoid arthritis, moderate to severe
☐ Other

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

Q5. For PLAQUE PSORIASIS, is the patient a candidate for systemic therapy or phototherapy?

☐ Yes ☐ No

Q6. Has the patient been screened for latent tuberculosis infection prior to initiation of treatment?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Acute complications associated with sickle cell disease ☐ Other

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

Q5. Is the patient 5 years of age or older?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 (NYHA) class II to IV heart failure
☐ The patient has reduced ejection fraction (left ventricular ejection fraction less than or equal to 40%)
☐ None of the above

Q5. For SYMPTOMATIC HEART FAILURE, does the patient 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 EXCLUSIONS (please select all that apply)?

COVERAGE DETERMINATION REQUEST FORM

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-inhibitor or ARB therapy
- ☐ Concomitant use, or use within 36 hours of an ACE-inhibitor
- ☐ Concomitant use with aliskiren in a diabetic patient
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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

☐ Yes ☐ No

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

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Non-metastatic castration-resistant prostate cancer
☐ Metastatic, castration-sensitive prostate cancer
☐ Other

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q7. Is the patient's partner pregnant?

☐ Yes ☐ No ☐ N/A

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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 as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Idiopathic pulmonary fibrosis (IPF) ☐ Other

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

Q5. Is the prescriber a pulmonologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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

☐ Initial therapy ☐ Continuing therapy

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

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

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

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

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

☐ Yes ☐ No

Q6. Will there be a dose reduction or interruption if the hemoglobin level exceeds one of the following: 10 g/dL (adult CKD not on dialysis, or cancer); 11 g/dL (CKD on dialysis); or 12 g/dL (pediatric CKD)?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Multiple myeloma ☐ Other

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

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

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

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

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

COVERAGE DETERMINATION REQUEST FORM

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

Date

COVERAGE DETERMINATION REQUEST FORM

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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Severe asthma with an eosinophilic phenotype ☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 specify the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested 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 around-the-clock opioid therapy for persistent cancer pain?

☐ Yes ☐ No

Q6. Are the patient and prescriber registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation Mitigation Strategy Access Program?

☐ Yes ☐ No

Q7. Will the medication be used for management of acute or post-operative pain, including headache/migraine, dental pain, or use in the emergency room?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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 opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine or an equianalgesic dose of another opioid).

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Lambert-Eaton myasthenic syndrome (LEMS) ☐ Other

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

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

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

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Firdapse-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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Fabry disease ☐ Other

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

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

Q6. Is the patient 16 years of age or older?
☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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

☐ Yes ☐ No

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

Q6. Do the patient's tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test?

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Extrapyramidal disease
☐ Parkinson's disease
☐ Other

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

Q5. For PARKINSON'S DISEASE, please select all that apply 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)?

COVERAGE DETERMINATION REQUEST FORM

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 consultation with, a neurologist?	
☐ Yes	☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Chronic renal insufficiency (CRI)
☐ Growth hormone deficiency (GHD), adult
☐ Growth hormone deficiency (GHD), pediatric
☐ Idiopathic short stature
☐ Noonan syndrome
☐ Prader-Willi syndrome
☐ Short-stature homeobox-containing gene (SHOX) deficiency
☐ Small for gestational age (SGA)
☐ Turner 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

COVERAGE DETERMINATION REQUEST FORM

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:**

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 been confirmed by genetic testing?

☐ Yes ☐ No

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 confirmed by chromosome analysis?

☐ Yes ☐ No

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 (GHD), please select all that apply to the patient:

- ☐ The patient has childhood or adult-onset 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
- ☐ 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

COVERAGE DETERMINATION REQUEST FORM

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 select 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 diabetic retinopathy
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 quantitative HCV RNA (viral load) testing any time prior to therapy:

Q6. Has the prescriber documented the following within 12 weeks of initiating therapy: CBC, INR, hepatic function panel, and GFR?

☐ Yes ☐ No

Q7. Is the patient post-transplant?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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 consultation with, one of the following (please select any that apply)?

- ☐ Gastroenterologist
- ☐ Hepatologist
- ☐ Infectious Disease Specialist
- ☐ None of the above

Q12. For Vosevi: Has the patient had trial and failure, contraindication, or intolerance to velpatasvir/sofosbuvir (Epclusa)?

☐ Yes ☐ No

Q13. If the patient has NOT tried the medication listed in the previous question, is there a reason why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hetlioz-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

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

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

Q5. Does the patient have documented blindness?

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hetlioz-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:**

COVERAGE DETERMINATION REQUEST FORM

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 written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Acute painful musculoskeletal conditions ☐ Other

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

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Humira-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 ULCERATIVE COLITIS, has the patient had an inadequate response to immunosuppressants (e.g., corticosteroids, azathioprine)?

☐ Yes ☐ No

Q8. Has the patient been screened for latent tuberculosis infection before initiation of treatment?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Breast cancer, advanced or metastatic ☐ Other

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

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

☐ Yes ☐ No

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

☐ In combination with an aromatase inhibitor
☐ In combination with fulvestrant (Faslodex) after disease progression following endocrine therapy
☐ None of the above

Q7. Please select which of the following applies to the patient:

☐ The patient is a man

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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 for the patient?

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Acute myeloid leukemia (AML), relapsed/refractory ☐ Other

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

Q5. Does the patient have an an isocitrate dehydrogenase 2 mutation as detected by an FDA approved test?
☐ Yes ☐ No

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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Idhifa-12 Medicare

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

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

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

☐ Chronic lymphocytic leukemia (CLL), with or without 17p deletion
☐ Mantle cell lymphoma (MCL)
☐ 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 received at least one (1) prior therapy?

☐ 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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Imbruvica-12 Medicare

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

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Patient Name:	**Prescriber Name:**

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

Q7. FOR GRAFT-VERSUS-HOST disease, has the patient 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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Parkinson's disease ☐ Other

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

Q5. Will the requested medication be used concurrently with carbidopa/levodopa?

☐ Yes ☐ No

Q6. Has the patient tried and failed or has a contraindication to one generic formulary alternative?

☐ Yes ☐ No

Q7. If the patient has NOT tried one generic formulary alternative, is there a reason why it cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Is the patient 18 years old or older?

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Inbrija-12 Medicare

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

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

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

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is the request for initial or continuing therapy?

☐ 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:

☐ Growth failure in a child with severe primary insulin-like growth factor 1 (IGF-1) deficiency
☐ Growth hormone (GH) gene deletion in a child who has developed neutralizing antibodies to GH
☐ Other

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 growth promotion in a patient with closed epiphyses
☐ The medication will be administered intravenously
☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Increlex-12 Medicare

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

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Patient Name:	**Prescriber Name:**

COVERAGE DETERMINATION REQUEST FORM

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is the request for initial or continuing therapy?

☐ 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:

☐ Myelofibrosis (MF), intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) ☐ Other

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Moderate to severe dyspareunia due to menopause
☐ Atrophic vaginitis due to menopause
☐ Other

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

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

☐ Yes ☐ No

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

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

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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 written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Non-small cell lung cancer, metastatic ☐ Other

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

Q5. Does the patient have known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 patient:

☐ Pituitary surgery has not been curative for this patient
☐ 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

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Isturisa-12 Medicare

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

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 drug that is being requested:

☐ Itraconazole capsules
☐ Itraconazole solution
☐ Other

Q4. If OTHER, please list the medication:

Q5. Please indicate the patient's diagnosis for the 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, please specify below:

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Itraconazole-13 Medicare

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

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Patient Name:	**Prescriber Name:**

Q7. For CANDIDIASIS, is the disease refractory to treatment 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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
IVIG-13 Medicare

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

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

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

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)
☐ Idiopathic or chronic immune thrombocytopenic purpura
☐ 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 select all that apply)?

☐ Acute corn or maltose hypersensitivity
☐ Hereditary fructose intolerance

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
IVIG-13 Medicare

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

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Patient Name:	**Prescriber Name:**

- ☐ Hyperprolinemia
- ☐ IgA deficiency with antibody formation and a history of hypersensitivity
- ☐ History of anaphylaxis or severe systemic reaction to human immune globulin
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Homozygous familial hypercholesterolemia ☐ Other

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

Q5. Has the diagnosis of homozygous familial hypercholesterolemia been confirmed by any of the following (please select all that apply)?

☐ 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 hypercholesterolemia in both parents
☐ None of the above

Q6. Please select any of the following that apply to the patient:

☐ The patient is pregnant

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Juxtapid-12 Medicare

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

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Patient Name:	**Prescriber Name:**

☐ The patient has moderate or severe liver impairment, or active liver disease including unexplained persistent abnormal liver function tests

☐ The requested medication will be used concomitantly with strong or moderate CYP 3A4 inhibitors

☐ None of the above

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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 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 requested medication:

☐ Cystic fibrosis ☐ Other

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

Q5. Does the patient have a cystic fibrosis transmembrane conductance regulator (CFTR) gene mutation that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 which medication this request is for:
☐ Kisqali ☐ Kisqali Femara

Q4. Please indicate the patient's diagnosis for the requested medication:
☐ Breast cancer, advanced or metastatic ☐ Other

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

Q6. Is the patient's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative?
☐ Yes ☐ No

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

Q8. Please indicate the patient's menopause status:

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 this medication *

☐ 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 patient:

☐ The patient has type 2 diabetes mellitus or glucose intolerance
☐ The medication will be used to control hyperglycemia secondary to hypercortisolism
☐ The patient has failed surgery
☐ 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?

COVERAGE DETERMINATION REQUEST FORM

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Neurofibromatosis type 1 (NF1) ☐ Other

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

Q5. Does the patient have symptomatic, inoperable plexiform neurofibromas (PN)?
☐ Yes ☐ No

Q6. Is the patient between 2 to 17 years of age?
☐ Yes ☐ No

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

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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 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 requested medication: *

☐ Hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU) ☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Endometrial carcinoma (advanced)
☐ Differentiated thyroid cancer (locally recurrent or metastatic, progressive)
☐ Liver carcinoma (unresectable)
☐ Renal cell carcinoma (advanced)
☐ Other

Q4. For ENDOMETRIAL CARCINOMA, please select all that apply to this patient:

☐ 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 is not a candidate for curative surgery or radiation
☐ None of the above

Q5. For THYROID CANCER, is the patient's disease refractory to radioactive iodine?

☐ Yes ☐ No

Q6. For RENAL CELL CARCINOMA, please select all that apply to this patient:

COVERAGE DETERMINATION REQUEST FORM

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 below:

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Acute myeloid leukemia, following completion of induction chemotherapy
☐ 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 syndrome (H-ARS)
☐ Myeloid reconstitution after autologous or allogeneic bone marrow transplant
☐ Autologous peripheral blood stem cell transplant following myeloablative chemotherapy
☐ Other

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

Q5. Does the patient have excessive (greater than or equal to 10%) leukemic myeloid blasts in bone marrow or peripheral blood?

☐ Yes ☐ No

Q6. Will the patient be receiving the requested medication concomitantly with myelosuppressive chemotherapy or

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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 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 indicate the start date (MM/YY):

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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

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

☐ Yes ☐ No

Q6. Please select any of the following that applies to the patient:

☐ The patient had disease progression on either alectinib (Alecensa) or ceritinib (Zykadia) as the first ALK inhibitor for metastatic disease

☐ The patient had disease progression on crizotinib (Xalkori) AND at least one other ALK inhibitor for metastatic disease

☐ None of the above

Q7. Will the requested medication be used concomitantly with strong CYP3A4 inducers?

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 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 requested 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 specify below.

COVERAGE DETERMINATION REQUEST FORM

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 why this medication cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q10. Please select all that apply to the patient:

- ☐ Patient is pregnant (in patients with child-bearing potential)
- ☐ Patient is breastfeeding
- ☐ Patient has undiagnosed abnormal vaginal bleeding
- ☐ None of the above or not applicable

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 select all that apply to this patient:

☐ The patient has a known or suspected BRCA mutation as detected by an FDA-approved test
☐ The patient has had trial and failure, contraindication, or intolerance to 3 or more prior lines of chemotherapy
☐ None of the above

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

☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative
☐ The patient has deleterious or suspected deleterious germline BRCA mutation (gBRCAm)
☐ The patient has been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting

COVERAGE DETERMINATION REQUEST FORM

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 select all that apply to this patient:

☐ The patient has deleterious or suspected deleterious germline BRCA-mutation

☐ The patient's disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen

☐ None of the above

Q8. For PROSTATE CANCER, please select all that apply to this patient:

☐ The patient has deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutation

☐ The patient's disease has progressed following prior treatment with enzalutamide or abiraterone

☐ None of the above

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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

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

☐ Yes ☐ No

Q6. Has the patient previously tried and failed any of the following medications?

☐ Avonex
☐ Betaseron
☐ Glatiramer
☐ Gilenya
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 consultation with) a neurologist?

☐ Yes ☐ No

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

☐ CYP2C9*3/*3 genotype

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

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

☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Anaplastic thyroid cancer, locally advanced or metastatic
☐ 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 patient have no satisfactory locoregional treatment options?

☐ Yes ☐ No

Q6. For ANAPLASTIC THRYOID CANCER OR NON-SMALL CELL LUNG CANCER, does the patient have BRAF V600E mutation?

☐ Yes ☐ No

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

COVERAGE DETERMINATION REQUEST FORM

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 monotherapy
- ☐ The patient has lymph node involvement, following complete resection
- ☐ None 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 consultation with, an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Malignant melanoma, unresectable or metastatic ☐ Other

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

Q5. Does the patient have documented BRAF V600E or V600K mutation as detected by a FDA-approved test?
☐ 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

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Attention deficit hyperactivity disorder (ADHD)
☐ Narcolepsy
☐ Other

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

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 justification:

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

COVERAGE DETERMINATION REQUEST FORM

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 presence of motor tics
- ☐ Concurrent use with MAOIs
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 which medication is being requested below:

☐ Avonex
☐ Betaseron
☐ Gilenya
☐ Glatiramer/Copaxone
☐ Tecfidera

Q4. For GILENYA, does the patient have any of the following (please select all that apply)?

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

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

☐ Baseline QTc interval greater than or equal to 500 milliseconds

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

☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 requested medication:

☐ Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS)
☐ Experienced a first clinical episode and has MRI features consistent with multiple sclerosis
☐ Other

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

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Hypoparathyroidism ☐ Other

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

Q5. Will the requested medication be used to control hypocalcemia?

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Breast cancer ☐ Other

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

Q5. Is the patient's disease human epidermal growth factor 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

COVERAGE DETERMINATION REQUEST FORM

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 consultation with) an oncologist?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Multiple myeloma ☐ Other

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

Q5. Will the requested medication be used in combination with lenalidomide (Revlimid) and dexamethasone?
☐ Yes ☐ No

Q6. Does the patient have history of at least one prior therapy?
☐ Yes ☐ No

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

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Neurogenic orthostatic hypotension (NOH) ☐ Other

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

Q5. Is the patient symptomatic?

☐ Yes ☐ No

Q6. Is the patient's diagnosis caused by one of the following (please select all that apply)?

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Northera-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

COVERAGE DETERMINATION REQUEST FORM

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 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 requested medication:
☐ Prostate cancer (non-metastatic, castration-resistant) ☐ Other

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

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

Q6. Is the requested medication prescribed by, or in consultation with, an oncologist or urologist?
☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Severe asthma with eosinophilic phenotype
☐ Eosinophilic granulomatosis with polyangiitis (EGPA)
☐ Other

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

Q5. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by, or in consultation with, a pulmonologist, rheumatologist, or immunologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Nucala-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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Pseudobulbar affect (PBA) ☐ Other

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ History of prolonged QT interval, congenital long QT syndrome or Torsades de pointes
☐ Heart failure
☐ Complete AV block without an implanted pacemaker or high risk of complete AV block
☐ Concomitant use with quinidine, quinine, mefloquine, or drugs that prolong QT interval and are metabolized by

COVERAGE DETERMINATION REQUEST FORM

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 (MAOIs) or within 14 days of MAOI therapy
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Parkinson's disease psychosis ☐ Other

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

Q5. Is the patient experiencing hallucinations and/or delusions?
☐ Yes ☐ No

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

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 options cannot be used (i.e., contraindication, history of adverse event, patient is not a candidate, etc.)?

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q6. Is the patient pregnant?

☐ Yes
☐ No
☐ Not applicable - patient is not a female of child-bearing potential

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Moderate to severe pain associated with endometriosis ☐ Other

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

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

☐ Yes ☐ No

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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Orilissa-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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Cystic Fibrosis (CF) ☐ Other

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

Q5. Does the patient have documented homozygous F508del mutation as confirmed by a FDA-approved CF mutation test?

☐ Yes ☐ No

Q6. Is the requested medication prescribed by, or in consultation with, a pulmonologist or prescribing practitioner from a CF center accredited by the Cystic Fibrosis Foundation?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause
☐ Moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause
☐ Other

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

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

☐ Yes ☐ No

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

☐ Undiagnosed abnormal genital bleeding
☐ Known or suspected estrogen-dependent neoplasia
☐ Active or history of deep vein thrombosis (DVT)
☐ Active or history of pulmonary embolism
☐ Active or history of arterial thromboembolic disease

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 select all that apply)?

- ☐ Extensive surgery
- ☐ Chronic infections
- ☐ Severe trauma
- ☐ Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons
- ☐ Chronic corticosteroid administration
- ☐ Bone pain associated with osteoporosis
- ☐ None of the above

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

- ☐ Breast or prostate cancer in men

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 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
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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:**

Q6. FOR CARDIOVASCULAR DISEASE: has the patient experienced any of the following? (please select all that apply):

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

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 mg/dL
- ☐ The requested medication will be used in combination with maximally tolerated high-intensity statin therapy
- ☐ Statins are not tolerated by the patient
- ☐ None of the above

Q10. If statins are contraindicated or not tolerated by the patient, please explain below:

Q11. Is the medication being prescribed by, or in consultation, 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 combination with maximally tolerated statin
- ☐ Statin therapy is not tolerated by the patient
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Chronic hepatitis B ☐ Chronic hepatitis C ☐ Other

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

Q5. Is the requested medication prescribed by, or in consultation 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 select all that apply)?

- ☐ Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon
- ☐ Uncontrolled depression
- ☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 genotype below:

Q8. For HEPATITIS C: Please provide the patient's initial HCV RNA level and, if continuing therapy, the current HCV RNA level and week of treatment:

Q9. For HEPATITIS C: Will the requested medication be used in conjunction with Sovaldi?

☐ Yes ☐ No

Q10. For HEPATITIS C: Is the patient treatment-naive or 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 patient has previously tried and the outcome of treatment (i.e., non-responder, relapser, etc.):

Q12. For HEPATITIS C: Please indicate all medications that will be part of the treatment regimen:

Q13. For HEPATITIS C: Please indicate the anticipated duration of therapy for this patient:

Q14. For HEPATITIS C: Does the patient have cirrhosis?

☐ Yes ☐ No

Q15. Does the patient have compensated liver disease?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Cholangiocarcinoma, unresectable locally advanced or metastatic ☐ Other

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

Q5. Has the patient been previously treated?

☐ Yes ☐ No

Q6. Does the patient's disease have confirmed fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by a FDA-approved test?

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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 consultation with an oncologist, gastroenterologist, or hepatologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Piqray-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Breast cancer, 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, and human epidermal growth factor receptor 2 (HER2)-negative?

☐ 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 combination with fulvestrant
☐ The patient's disease has progressed on or after an endocrine-based regimen

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Piqray-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 consultation with) an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 completion of the last therapy
☐ Patient has been counseled about the use of two forms of reliable contraception before, during, and one month after discontinuing therapy
☐ Patient has been assessed to determine if prophylactic aspirin or antithrombotic treatment (warfarin, clopidogrel) will need to be taken to reduce the risk of VTE (embolism, stroke)
☐ Patient is registered and certified to be compliant with Pomalyst REMS program
☐ None of the above

Q6. For FEMALES OF CHILD-BEARING POTENTIAL, please select all that apply:

☐ Patient is not pregnant

COVERAGE DETERMINATION REQUEST FORM

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 prior to initiation of therapy
- ☐ Patient will receive monthly pregnancy tests during therapy
- ☐ Patient is male or not of reproductive potential
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Chronic idiopathic thrombocytopenic purpura (ITP)
☐ Severe aplastic anemia
☐ Thrombocytopenia associated with chronic hepatitis C infection
☐ Other

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

Q5. For APLASTIC ANEMIA, please select any of the following that apply to the patient:

☐ The patient had an insufficient response to immunosuppressive therapy
☐ The requested medication will be used in combination with standard immunosuppressive therapy
☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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.**

Patient Name:	**Prescriber Name:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Gastrointestinal stromal tumor, advanced ☐ Other

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

Q5. Has the patient received prior treatment with 3 or more kinase inhibitors, including imatinib?

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 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 adequate 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 the site of application?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Medullary thyroid cancer, RET-mutant (advanced or metastatic)
☐ Non-small cell lung cancer, RET fusion-positive (metastatic)
☐ Thyroid cancer, RET fusion-positive (advanced or metastatic)
☐ Other

Q4. For MEDULLARY THYROID CANCER, does the patient require systemic therapy (such as the requested medication)?

☐ Yes ☐ No

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

☐ The patient requires systemic therapy (such as the requested medication)
☐ The patient is refractory to radioactive iodine, if appropriate
☐ None of the above

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

COVERAGE DETERMINATION REQUEST FORM

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 consultation with) an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 below:

Q5. For FOLLICULAR LYMPHOMA or MARGINAL ZONE LYMPHOMA, will the requested medication be used in combination with rituximab (Rituxan)?

☐ Yes ☐ No

Q6. For MANTLE CELL LYMPHOMA, has the patient's disease relapsed or progressed after two (2) prior therapies (one of which included bortezomib [Velcade])?

COVERAGE DETERMINATION REQUEST FORM

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 requested medication will be used in this patient:

- ☐ In combination with dexamethasone
- ☐ Following autologous hematopoietic stem cell transplantation
- ☐ None of the above

Q8. For TRANSFUSION-DEPENDENT ANEMIA, is the patient's condition due to low- or intermediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q cytogenetic abnormality or without additional cytogenetic abnormalities?

☐ Yes ☐ No

Q9. Is the patient pregnant?

- ☐ Yes
- ☐ No
- ☐ Not applicable - the patient is not a female of child-bearing potential

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Rheumatoid arthritis, moderate to severe ☐ Other

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

Q5. Has the patient had an inadequate response or intolerance to methotrexate?
☐ Yes ☐ No

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ ROS1-positive metastatic non-small cell lung cancer (NSCLC)
☐ Solid tumors
☐ Other

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

Q5. For SOLID TUMORS, please select all that apply to the patient:

☐ The disease has a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation
☐ The disease is metastatic or surgical resection is likely to result in severe morbidity
☐ The disease has either progressed following treatment or has no satisfactory alternative therapy
☐ None of the above

Q6. Is the requested medication prescribed by, or in consultation with, an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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:	**Prescriber Name:**

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Deleterious BRCA mutation (germline and/or somatic)-associated ovarian, fallopian tube, or primary peritoneal cancer
☐ Recurrent ovarian, fallopian tube, or primary peritoneal cancer
☐ Other

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

Q5. Please select all that apply to the patient:

☐ The patient is BRCA mutation-positive as detected by an approved FDA laboratory test
☐ The patient has had previous trial with inadequate response (failure) to two or more chemotherapy regimens
☐ The patient has had a complete or partial response to platinum-based chemotherapy
☐ The requested medication will be used as monotherapy
☐ The provider agrees to perform a complete blood count (CBC) at baseline and monthly thereafter
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 an effective method of contraception be used during therapy and for 6 months after the last dose?

- ☐ Yes
- ☐ No
- ☐ N/A - The patient is not 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 experienced disease progression or unacceptable toxicity?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Acute myelogenous leukemia (AML)
☐ Mast cell leukemia
☐ Systemic mastocytosis
☐ Other

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

COVERAGE DETERMINATION REQUEST FORM

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 consultation with, an oncologist or hematologist?	
☐ Yes	☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 less with marked hyponatremia that is symptomatic and has resisted correction with fluid restriction?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Anuria

COVERAGE DETERMINATION REQUEST FORM

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

Date

COVERAGE DETERMINATION REQUEST FORM

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:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Pulmonary arterial hypertension (PAH), WHO Group 1 ☐ Other

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

Q5. Was the patient's diagnosis confirmed by right heart catheterization or Doppler echocardiogram if the patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?

☐ Yes ☐ No

Q6. Is the patient currently on nitrate therapy?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:	**Prescriber Name:**

COVERAGE DETERMINATION REQUEST FORM

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 as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Plaque psoriasis, moderate to severe ☐ Other

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

Q5. Is the patient an adult who is a candidate for systemic therapy (such as the requested medication) or phototherapy?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 patient:

☐ Patient had an inadequate response to surgery and/or radiation therapy
☐ Patient is ineligible for surgery and/or radiation therapy
☐ 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 consultation with, an endocrinologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL)
☐ Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML)
☐ Other

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

Q5. For ACUTE LYMPHOBLASTIC LEUKEMIA, please select 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 phase with resistance or intolerance to prior therapy
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 consultation with, an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Crohn's disease, moderately to severely active
☐ Plaque psoriasis, moderate to severe
☐ Psoriatic arthritis, active
☐ Ulcerative colitis, moderate to severely active
☐ Other

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

Q5. Has the patient tried and failed (or has a contraindication or intolerance to) any of the following (please select all that apply)?

☐ Enbrel ☐ Humira ☐ None of the above

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.)?

COVERAGE DETERMINATION REQUEST FORM

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 consultation with) any of the following?

- ☐ Rheumatologist
- ☐ Gastroenterologist
- ☐ Dermatologist
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 mutation-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 chemotherapy
☐ Anti-VEGF bevacizumab (Avastin)
☐ Anti-EGFR panitumumab (Vectibix) or cetuximab (Erbitux)

COVERAGE DETERMINATION REQUEST FORM

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 the patient been previously treated with any of the following (please select all that apply)?

☐ Imatinib (Gleevec) ☐ Sunitinib (Sutent) ☐ None of the above

Q9. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q10. For LIVER CARCINOMA, has the patient been previously treated with sorafenib (Nexavar)?

☐ 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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Narcolepsy with excessive daytime drowsiness
☐ Obstructive sleep apnea (OSA) with excessive daytime sleepiness
☐ Other

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

Q5. Does the patient have trial of/or contraindication to any of the following? (Please select all that apply.)

☐ Armodafinil ☐ Modafinil ☐ None 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

COVERAGE DETERMINATION REQUEST FORM

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 select all that apply.)

- ☐ Concomitant use of a monoamine oxidase inhibitor (MAOI)
- ☐ Use within 14 days of discontinuing a monoamine oxidase inhibitor (MAOI)
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Gastrointestinal stromal tumor
☐ Pancreatic neuroendocrine tumors, unresectable locally 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 patient had disease progression on or intolerance to imatinib (Gleevec)?

☐ 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:

COVERAGE DETERMINATION REQUEST FORM

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 therapy following nephrectomy in a patient who is at high risk for recurrence
☐ None of the above

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Melanoma with microscopic or gross nodal involvement ☐ Other

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

Q5. Will the requested medication be used as adjuvant treatment within 84 days of definitive surgical resection, including complete lymphadenectomy?

☐ Yes ☐ No

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

☐ Autoimmune hepatitis
☐ Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Cystic fibrosis ☐ Other

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

Q5. Please select if any of the following apply to the patient:

☐ Patient is homozygous for the F508del mutation

☐ Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-cleared CF mutation test

☐ None of the above

Q6. Is the patient 6 years of age or older?

☐ Yes ☐ No

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Diabetes mellitus (type 1 or type 2) ☐ Other

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

Q5. Does the patient use mealtime insulin therapy and has failed to achieve desired glucose control?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Confirmed diagnosis of gastroparesis
☐ Hypoglycemia unawareness
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 leads to mesenchymal-epithelial 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 consultation with an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Anaplastic thyroid cancer, locally advanced or metastatic
☐ 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 select 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 patient:

☐ Patient has BRAF V600E or V600K mutation

COVERAGE DETERMINATION REQUEST FORM

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 monotherapy
☐ The requested medication will be used in combination with trametinib (Mekinist)
☐ The requested medication will be used as adjuvant therapy following complete resection in a patient with lymph node involvement
☐ None of the above

Q7. For NON-SMALL CELL LUNG CANCER, please select all that apply to the patient:
☐ Patient has BRAF V600E mutation
☐ The requested medication will be used in combination with trametinib (Mekinist)
☐ 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 consultation with, an oncologist?
☐ Yes ☐ No

Prescriber Signature _____ Date _____

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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

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 EGFR tyroskine kinase inhibitor-based therapy
☐ None of the above

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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 consultation with, an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Hereditary angioedema ☐ Other

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

Q5. Is the requested medication being used for the prevention of attacks?
☐ Yes ☐ No

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Breast cancer, locally advanced or metastatic ☐ Other

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

Q5. Does the patient have deleterious or suspected deleterious germline BRCA-mutation (gBRCAm)?
☐ Yes ☐ No

Q6. Is the patient's disease human epidermal growth factor receptor 2 (HER2)-negative?
☐ Yes ☐ No

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

Q8. Is the requested medication prescribed by, or in consultation with, an oncologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 indicate the start date (MM/YY):

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

☐ Primary cutaneous T-cell lymphoma (CTCL Stage 1A/1B) ☐ Other

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

Q5. Has the patient had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy (e.g., corticosteroids) indicated for cutaneous manifestations of CTCL?

☐ Yes ☐ No

Q6. If the patient has NOT tried any systemic therapies, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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 consultation with, an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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 select 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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 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 EZH2 mutation as detected by a FDA-approved test
☐ The patient has received at least 2 prior systemic therapies
☐ The patient has no satisfactory alternative treatment options
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 consultation with) an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Polyneuropathy of hereditary transthyretin-mediated amyloidosis ☐ Other

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

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

☐ Yes ☐ No

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

☐ Platelet count less than 100,000 per microliter
☐ Urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher
☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Hypogonadism, hypogonadotropic or primary
☐ Inoperable metastatic breast cancer
☐ Other

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

Q5. For BREAST CANCER, is the patient postmenopausal?

☐ Yes ☐ No ☐ Not applicable

Q6. For HYPOGONADISM, has the diagnosis been confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value?

☐ Yes ☐ No

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

☐ Carcinoma of the breast or prostate

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

EOC 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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Chorea associated with Huntington's disease ☐ Other

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

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

- ☐ 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
- ☐ None of the above

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC 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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Multiple myeloma, newly diagnosed
☐ Erythema nodosum leprosum (ENL)
☐ Other

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

Q5. Is the requested medication prescribed by, or in consultation with, an oncologist or infectious disease specialist?

☐ Yes ☐ No

Q6. Is the patient pregnant?

☐ Yes
☐ No
☐ Not applicable - the patient is not of child-bearing potential

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 dehydrogenase-1 mutation
☐ The patient is 75 years of age or older
☐ The patient has comorbidities that preclude intensive induction chemotherapy
☐ None of the above

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 indicate Start Date:

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

☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Other

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

Q5. Does the patient have a history of failure, contraindication, or intolerance to any of the following formulary alternatives?

- ☐ Advair Diskus
- ☐ Anoro Ellipta
- ☐ Breo Ellipta
- ☐ Fluticasone/Salmeterol
- ☐ Serevent Diskus
- ☐ Spiriva HandiHaler
- ☐ Spiriva Respimat
- ☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 used (i.e. contraindication, history of adverse event, etc)?

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 the cystic fibrosis transmembrane conductance regulator (CFTR) gene verified by an FDA-cleared CF mutation test?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q7. Is the requested medication prescribed by (or in consultation with) any of the following?

☐ Prescriber from a CF center accredited by the Cystic Fibrosis Foundation
☐ Pulmonologist
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 factor receptor 2 (HER2)-positive
☐ The requested medication will be used in combination with trastuzumab and capecitabine
☐ The patient has received one or more prior anti-HER2 based regimens in the metastatic setting
☐ 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 consultation with) an oncologist?

COVERAGE DETERMINATION REQUEST FORM

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

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 morbidity or functional limitations
☐ The patient's disease is not amenable to improvement with surgery
☐ 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 consultation with, an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 multiple risk factors for fracture?

☐ Yes ☐ No

Q6. Has the patient had previous trial and failure, contraindication, or intolerance to any of the following (please select all that apply)?

☐ Bisphosphonate ☐ Prolia ☐ 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.)?

COVERAGE DETERMINATION REQUEST FORM

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 the patient's lifetime?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Pulmonary arterial hypertension (PAH), World Health Organization (WHO) Group 1 ☐ Other

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

Q5. Has the patient's diagnosis been confirmed by right heart catheterization?

☐ Yes ☐ No

Q6. Has the patient tried and had an insufficient response to at least one other PAH agent therapy (e.g., sildenafil)?

☐ Yes ☐ No

Q7. If the patient has NOT tried any PAH agents, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
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

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 indicate the start date (MM/YY):

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

☐ Acute myeloid leukemia (AML), newly diagnosed
☐ Chronic lymphocytic leukemia (CLL)
☐ Small lymphocytic lymphoma (SLL)
☐ Other

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

Q5. For ACUTE MYELOID LEUKEMIA, please select all that apply to the patient:

☐ The patient is 75 years of age or older
☐ The patient has comorbidities that preclude the use of intensive induction chemotherapy
☐ The requested medication will be used in combination with azacitidine, decitabine or low-dose cytarabine
☐ None of the above

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

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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 consultation with, an oncologist?

☐ Yes ☐ No

Q8. For CHRONIC LYMPHOCYTIC LEUKEMIA OR SMALL LYMPHOCYTIC LEUKEMIA, will the patient use a strong CYP3A inhibitor concomitantly during the initial and titration phase?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Breast cancer, advanced or metastatic ☐ 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 hormone receptor (HR)-positive

☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative

☐ The requested medication is being used in combination with fulvestrant for the treatment of disease progression following endocrine therapy

☐ The requested medication is being used as monotherapy for the treatment of disease progression following endocrine therapy

☐ The requested medication is being used as initial endocrine-based treatment in combination with an aromatase inhibitor

☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

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 contraindication to any of the following (please select all that apply)?

☐ Ibrance ☐ Kisqali ☐ None of the above

Q8. 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.)?

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

☐ Yes ☐ No

Q10. Is the requested medication prescribed by, or in consultation with, an oncologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Solid tumors ☐ 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 metastatic or surgically unresectable
☐ The patient's disease is neurotrophic receptor tyrosine kinase (NTRK) gene fusion-positive
☐ The patient has unsatisfactory alternative treatments or has progressed following treatment
☐ None of the above

Q6. Is the requested medication prescribed by, or in consultation with, an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations 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 consultation with, an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Transthyretin related familial amyloid cardiomyopathy (wild type or hereditary) ☐ Other

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

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

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

Q5. Is the patient's disease anaplastic lymphoma kinase (ALK)-positive or ROS1-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 consultation with, an oncologist?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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 (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 requested medication:

☐ Psoriatic arthritis, active
☐ Rheumatoid arthritis, moderate to severe
☐ Ulcerative colitis, moderate to severe
☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:

☐ Bone metastases from a solid tumor
☐ Giant cell tumor of the bone
☐ Hypercalcemia of malignancy
☐ Prevention of skeletal-related events associated with multiple 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?

☐ Yes
☐ No

COVERAGE DETERMINATION REQUEST FORM

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, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Does the patient have hypocalcemia (calcium less than 8.0 mg/dL)?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested 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 therapy?

☐ 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 patient:

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication:
☐ Acute myeloid leukemia, relapsed or refractory ☐ Other

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

Q5. Does the patient have a presence of FLT3 mutation 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 consultation with, an oncologist or hematologist?
☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xpovio-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ 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 patient received at least 2 lines of systemic therapy?

☐ Yes ☐ No

Q6. For MULTIPLE MYELOMA, will the requested medication be used in combination with dexamethasone?

☐ Yes ☐ No

Q7. For MULTIPLE MYELOMA, has the patient received at least 4 prior therapies?

☐ Yes ☐ No

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xpovio-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. For MULTIPLE MYELOMA, is the patient's disease refractory to any of the following? (Please select all that apply.)

- ☐ At least two proteasome inhibitors
- ☐ At least two immunomodulatory agents
- ☐ An anti-CD38 monoclonal antibody
- ☐ None of the above

Q9. If the patient has NOT tried any of the medications listed in the previous question(s), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

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

☐ Yes ☐ No

Q11. Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Prostate cancer (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 oncologist or urologist?

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xtandi-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:**

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xuriden-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Hereditary orotic aciduria ☐ Other

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

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Narcolepsy with cataplexy
☐ Narcolepsy with excessive daytime sleepiness
☐ Other

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

Q5. Is the patient 7 years of age or older?

☐ Yes ☐ No

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

☐ Concomitant treatment with sedative hypnotic agents
☐ Succinic semialdehyde dehydrogenase deficiency
☐ None of the above

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Xyrem-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

COVERAGE DETERMINATION REQUEST FORM

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:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
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 requested medication below:

☐ Prostate cancer (metastatic, castration-resistant) ☐ Other

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

Q5. Is the requested medication being used in combination with methylprednisolone?

☐ Yes ☐ No

Q6. Does the patient have documented history of trial with, inadequate treatment response, adverse event, or contraindication to Zytiga (abiraterone)?

☐ 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.)?

COVERAGE DETERMINATION REQUEST FORM

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 consultation 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

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zarxio-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is the request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Autologus peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis
☐ Chemotherapy-induced febrile neutropenia, prophylaxis
☐ Hematopoietic subsyndrome of acute radiation syndrome (H-ARS)
☐ Neutropenia
☐ Other

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

Prescriber Signature Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Advanced or recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent 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 platinum-based chemotherapy (e.g., cisplatin, carboplatin)

☐ None of the above

Q5. For ADVANCED OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER, please select all that apply to this patient:

☐ The patient has been treated with 3 or more prior 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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zejula-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's disease has progressed more than 6 months after response to the last platinum-based chemotherapy

☐ None of the above

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zykadia-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

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

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

Q3. Please indicate the patient's diagnosis for the requested medication:
☐ Metastatic non-small cell lung cancer (NSCLC) ☐ 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

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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zykadia-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

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Zytiga-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 name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

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

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

☐ Metastatic prostate cancer, castration-resistant
☐ Metastatic prostate cancer, high-risk, castration-sensitive
☐ Other

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

Q5. Is the requested medication being used combination with prednisone?

☐ Yes ☐ No

Prescriber Signature

Date