COVERAGE DETERMINATION REQUEST FORM

EOC ID:
PPI-12 Medicare

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

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

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

☐ Erosive esophagitis
☐ Gastroesophageal reflux disease (GERD)
☐ Other

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

Q5. Has the patient tried and failed any of the following? (please select all that apply)

☐ Lansoprazole
☐ Esomeprazole
☐ Omeprazole
☐ Pantoprazole
☐ Rabeprazole
☐ None of the above

Q6. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these

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

Prescriber Signature

Date

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Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please 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:

☐ Gout ☐ Other

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

Q5. Has the patient tried and failed ALLOPURINOL?

☐ Yes ☐ No

Q6. If the patient has NOT tried ALLOPURINOL, please indicate the reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

Prescriber Signature

Date

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