

BIOPHARMACY COVERAGE DETERMINATION REQUEST FORM

Patient Name			Prescriber Name		
Member ID #			Prescriber NPI# (required)		
Sex (circle) M F	DOB		Office Phone	Office Fax	
Tax ID # (required)			Servicing Provider (if applicable)		
Contact Person			Servicing Provider NPI# (required)		
Medication		Strength	Route of Administration	Frequency (How Often)	
<input type="checkbox"/> New Prescription OR Date Therapy Began			Duration of Therapy (in time)	Qty (For Rx Benefit Only)	
Height	Weight	Allergies	Diagnosis	ICD10 Code	
PRESCRIBER'S SIGNATURE				Date	

This section must be completed. Incorrect completion may result in delays in reimbursement or provision of service.

The medication will be obtained through either (**select only 1**):

- The medical benefit ("Buy and Bill"). Medication JCode (required) _____
Medication Billable Units (required) _____
- The pharmacy benefit (member to pick up at **pharmacy only**)

Rationale for Exception Request or Prior Authorization (Must attach supporting clinical notes)

- Alternate covered drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) and completed MedWatch Form. **Specify:** (1) Covered drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each;
- Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. **Specify:** (1) Anticipated significant adverse clinical outcome;
- Medical need for different dosage form and/or higher dosage; **Specify:** (1) New dosage form; (2) Dosage tried; (3) documented medical reason
- Other: _____ (Explain below)

Required Explanation:

Disclaimer:

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.