NextLevelHealth
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Return completed request and Medical Record documentation to:
Fax: 844-776-1664
If you have any questions, call:
Phone: 833-275-6547

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)
☐ 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:

Revised: May 2018