Provider Partners Health Plans

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Phone: 1-844-846-8007 Fax back to: 1-877-503-7231

Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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):	

The request will be processed as written, including drug name, with no substitution.

Drug Name and Strength:

Directions / SIG:

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard review timeframes (72 hours for initial requests or 7 days for appeals) may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

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 provide the patient's diagnosis for the requested medication below:

Q4. What is the quantity of medication that is being requested per 30 days?

Q5. What is the anticipated duration of therapy?

☐ Less than one month
☐ One to three months
☐ Three months to one year
☐ Lifetime

Q6. Please list all medications the patient has previously tried for the requested diagnosis below, along with the dates and outcomes, including response to therapy (i.e. ineffective, adverse reaction, contraindication, etc):

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date