COVERAGE DETERMINATION REQUEST FORM

EOC ID:

AMWINS Non-Formulary and Excluded Drugs-5c Request

Phone: 855-693-3920 Fax back to: 866-650-3622

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax 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):	

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 indicate Start Date:

Q3. Please provide the patient's diagnosis for the requested medication below.

Q4. Has the patient tried and failed or had contraindications or intolerance to at least THREE equivalent formulary drugs? If only one or only two equivalents are available, the patient must have failed or had contraindications or intolerance to all available equivalent formulary drugs

☐ Yes
☐ No
☐ There are no formulary drugs which are appropriate to treat the patient's condition

Q5. Please list all medications the patient has previously tried for the requested diagnosis along with the date and response to therapy (i.e. ineffective, adverse reaction, contraindication, etc):

Q6. If No formulary drug is appropriate to treat the patient's condition, please check all that apply:

☐ The requested drug is FDA-approved for the condition being treated AND Additional requirements listed in the "Indications and Usage" sections of the prescribing information (or package insert) have been met (e.g., first line therapies have been tried and failed, any testing requirements have been met, etc)

☐ If requested for an off-label indication, the off-label guideline approval criteria have been met

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☐ None of the above

Prescriber Signature

Date