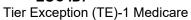


COVERAGE DETERMINATION REQUEST FORM

EOC ID:





Phone: 833-697-6561 Fax back to: 877-503-7231

MedImpact 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 MedImpact will process the request as	written, including di	rug name, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		-
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that ma estions and sign.	ay support approval. Please answer the
	conono una oigii.	
Q1. Is this request for initial or continuing therapy?		
Q1. Is this request for initial of continuing therapy:		
☐ Initial therapy	☐ Continuing the	erapy
Q2. Please provide the patient's diagnosis for the request	ed medication:	
		<u> </u>
Q3. Please list all medications that were tried and failed for	or the submitted diagno	OSIS:
Q4. If formulary alternatives not listed in the previous ques	stion are contraindicate	ed or not appropriate, provide
reason(s) why.		
Prescriber Signature		Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tier Exception (TE)-1 Medicare

Phone: 833-697-6561 Fax back to: 877-503-7231

MedImpact 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.

Prescriber Name:

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