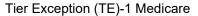


COVERAGE DETERMINATION REQUEST FORM

EOC ID:





Phone: 866-250-2005 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.

Date of Birth: Group Number: Address: Address: City, State ZIP: Primary Phone: **Please note that MedImpact will process the request as written, including drug name, with no substitution. Expedited/Urgent	Patient Name:	Prescriber Name:	
Group Number: Address: Address: Address: City, State ZIP: City, State ZIP: Primary Phone: Speciality/facility name (if applicable): *Please note that MedImpact will process the request as written, including drug name, with no substitution. Expedited/Urgent	Member/Subscriber Number:	Fax:	Phone:
Address: City, State ZIP: Primary Phone: **Please note that MedImpact will process the request as written, including drug name, with no substitution. Expedited/Urgent	Date of Birth:	Office Contact:	
City, State ZIP: Primary Phone: *Please note that Medimpact will process the request as written, including drug name, with no substitution. Expedited/Urgent	Group Number:	NPI:	State Lic ID:
Primary Phone: **Please note that MedImpact will process the request as written, including drug name, with no substitution. Expedited/Urgent	Address:	Address:	
*Please note that MedImpact will process the request as written, including drug name, with no substitution. Expedited/Urgent	City, State ZIP:	City, State ZIP:	
Drug Name and Strength: Directions / SIG: 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 Q2. Please provide the patient's diagnosis for the requested medication: Q3. Please list all medications that were tried and failed for the submitted diagnosis: Q4. If formulary alternatives not listed in the previous question are contraindicated or not appropriate, provide reason(s) why.	Primary Phone:	Specialty/facility name (if appl	icable):
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Drocaribor Signature			
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Drocavibar Signatura			
Prescriper Signature	Prescriber Signature		 Date



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Tier Exception (TE)-1 Medicare

Phone: 866-250-2005 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:
ralielii ivallie.	Flescibel Name.

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