COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Reference Pricing Program-1c (MPD) Request

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:**	
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 drug name, with no substitution.

☐ Expedited/Urgent

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 ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:

Q4. Has the patient tried the therapeutic alternative?

☐ Yes ☐ No

Q5. Did the patient experience adverse effects that resulted in discontinuation of the therapeutic alternative?

☐ Yes ☐ No

Q6. Is use of the therapeutic alternative contraindicated with other medications?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q7. Please specify reason therapeutic alternative is contraindicated with other medications:

Q8. Did the patient fail to achieve the therapy goal after an adequate trial of the therapeutic alternative?

☐ Yes ☐ No

Q9. Please provide any additional information to be considered and used in determination of this exception:

Prescriber Signature

Date