



Coverage determination request form.

EOC ID: MedImpact Non Formulary Exception (NFE) Request

Phone: 800-361-4542 Fax back to: 866-414-3453

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.**

Drug Name and Strength:

Expedited / Urgent

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval.

Please answer the following questions and sign.

<p>Q1: Is this request for initial or continuing therapy?</p> <p><input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy</p>
<p>Q2: For CONTINUING THERAPY, please provide the start date (MM/YY):</p>
<p>Q3: Please provide the patient's diagnosis for the requested medication:</p>
<p>Q4: 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):</p>
<p>Q5: If the patient has not tried any formulary alternatives, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)? Please specify:</p>

Q6: Please check all that apply to this patient:

- | | |
|---|---|
| <input type="checkbox"/> Patient has an allergy to all formulary alternatives | <input type="checkbox"/> Patient has an indication (a medical condition) that is unique to a non-preferred drug and is supported by a compendia or a unique federal Food and Drug Administration approved indication (medical condition) |
| <input type="checkbox"/> Patient has a contraindication (reason not to take) or drug-to-drug interaction to all formulary alternatives | <input type="checkbox"/> Patient has an age-specific indication (medical condition), medical co-morbidity (having more than one medical condition at the same time), or other medical complication that precludes the use of a preferred drug |
| <input type="checkbox"/> Patient has a history of unacceptable or toxic side effects to all formulary alternatives | <input type="checkbox"/> There is a clinically unacceptable risk with a change in therapy to a preferred drug |
| <input type="checkbox"/> Patient has had therapeutic failure (poor response with) to all formulary alternatives | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Patient has a history of unacceptable or toxic side effects to all formulary alternatives on the preferred drug list | |

Prescriber Signature

Date

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