Fill at Delmarva Pharmacy

Return completed request and Medical Record documentation to:
Fax: 800-953-8856
If you have any questions, call:
Phone: 800-953-8854

PHARMACY COVERAGE DETERMINATION REQUEST FORM

Patient Name	Prescriber Name
Member ID#	NPI#(required)
Sex (circle) M F	Office Phone
DOB	Office Fax
Home Phone:	Contact Person

Medication	Strength	Route of Administration	Frequency
☐ New Prescription OR Date Therapy Began		Expected Length of Therapy	Qty
Height/Weight	Allergies	Diagnosis	ICD10 Code
PRESCRIBER'S SIGNATURE			Date

This section must be completed. Incorrect completion may result in delays in reimbursement or provision of service.

The medication will be obtained through either (***select only 1***):

☐ The medical benefit ("Buy and Bill")

Medication HCPCS Code (required) _______________ Units ______________

☐ The pharmacy benefit (member pick up at pharmacy)

Rationale for Exception Request or Prior Authorization

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) and completed Medwatch Form. **Specify:** (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each; (4) **Attach supporting clinical notes**

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. **Specify:** (1) Anticipated significant adverse clinical outcome; (2) **Attach supporting clinical notes**

☐ Medical need for different dosage form and/or higher dosage; **Specify:** (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason; (3) **Attach supporting clinical notes**

☐ Other:____(1) Explain below; (2) **Attach supporting clinical notes**

Required Explanation

Disclaimer:
This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.