Pharmacy Coverage Determination Form

Formulary: http://www.WindsorExtra.com/provider.html
Formulary: http://www.WindsorRx.com/physicians.html

Please complete ALL FIELDS and fax this form to the Windsor Pharmacy Department at (801) 245-3862. For assistance, you may contact us at 1-866-715-7519 (MAPD) or 1-800-264-1587 (PDP), 8am – 6pm (CST), M-F. Coverage Determination criteria is available upon request. This form cannot be used to request Medicare excluded drugs such as barbiturates, benzodiazepines, fertility, weight loss or gain, hair growth, or prescription vitamins (except for prenatal/fluoride).

❑ **Prior Approval** ❑ **Step Therapy Override** ❑ **QLL Override**
❑ **Non-Formulary Exception** ❑ **Tiering Exception *(not applicable to Specialty Injectables)***

***REQUIRED FIELDS – USE BLACK INK (One Medication Per Form)**

*Patient Name		*Medication, Strength and Route of Administration:	
*Windsor Medicare Extra ID # (On Front of ID Card):		*Quantity and Frequency:	
*Patient Height/Weight/BMI:	*Date of Birth:	*Expected Length of Therapy:	*Drug Allergies:
*Physician FULL Name / Specialty:		*Diagnosis/ICD-9:	
*Contact Name in MD Office:		Has member been on medication in the past? ❑Yes ❑No If yes, for how long?	
*Office Phone:	Office Fax:	If injectable, is patient self-administering drug? ❑Yes ❑No If no, who will administer drug?	
*Pharmacy Name & Phone:		IF TRANSPLANT DRUG: Was the transplant covered by Medicare Part A? ❑Yes ❑No If yes, give date:	

Rationale for Exception Request or Prior Authorization:
NOTE: FORM CAN NOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

❑ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)
→Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy for drug(s);

❑ 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 below: Anticipated significant adverse clinical outcome

❑ Medical need for different dosage form &/or higher dosage
→Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

❑ Request for formulary tier exception
→Specify below: (1) Formulary or preferred drugs contraindicated or tried & failed, or tried & not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

❑ Other: _____ → Explain below

REQUIRED EXPLANATION: _____

_____

❑ REQUEST FOR EXPEDITED REVIEW [24 HOURS]
→ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

PLEASE FAX ALONG WITH THIS REQUEST: Other History related to this request, <u>THE LAST TWO OFFICE VISIT NOTES and LABORATORY RESULTS IF APPLICABLE</u> (e.g. lab values, culture/sensitivity results, Hgb A1C, Serum Creatinine, CD4, CBC, etc).

Physician Signature: _____ **Date:** _____

Date & Time Rcd:	**Initials:**	**Date & Time Approved:**	**Length of Approval:**
Date & Time Denied:	**Reason for Denial:**		**Notes:**

Standard Coverage Determination will be made in 72 hours. Expedited Coverage Determinations will be made in 24 hours. Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.