ENVISIONRx

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Non Formulary Exception (NFE)-1c Request

Phone: 844-838-1522 Fax back to: 866-414-3453

EnvisionRxOptions 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):	

☐ 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 indicate Start Date:

Q3. Please provide the patient's diagnosis for the requested medication below.

Q4. What is the anticipated duration of therapy?

- ☐ Less than a month
- ☐ One to three months
- ☐ Three months to one year
- ☐ Lifetime

Q5. Has the patient tried any TWO formulary alternatives for the requested medication? (or one if only one is available)

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. 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):

Q7. If the patient has an intolerance, inadequate response, or contraindication to two (2) formulary alternatives, has the prescriber submitted documentation (by labs or chart notes)?

☐ Yes ☐ No

Prescriber Signature

Date