PO Box 221138, Chantilly, VA 20153-1138

FACSIMILE COVER LETTER

Confirmed Recipient Name:	**Sender's Name/Title:**
Confirmed Recipient Fax Number:	**Sender's Fax Number:** **1-866-617-4900**
Confirmed Recipient Phone Number:	**Sender's Phone Number:**
Date:	**No. of Pages (including fax cover sheet)**
Notes: **Please complete the attached form and return to the sender's fax number noted above. Thank you.**	

Precertification Request for Prescription Medications

Fax this form to: 1-866-617-4900
For faster service, please call <MORG ADD 3>.

Patient Information		Prescriber Information	
Patient Name <PT FIRST NAME> <PT LAST NAME>		Today's Date <CUR DATE FULL>	
Patient Insurance ID Number		Physician Name <EVT PROV PREFIX> <EVT PROV FIRST NAME> <EVT PROV LAST NAME>	
Patient Address, City, State, Zip <PT ADD 1> <PT ADD 2> <PT CITY> <PT STATE> <PT ZIP>		Physician Address	
Home Telephone <PT PHONE 2>		M.D. Office Telephone Number <EVT PROV PHONE>	
Gender ☐ Male ☐ Female	Patient Date of Birth <PT DOB>	M.D. Office Fax Number <EVT PROV FAX>	

Diagnosis and Medical Information

Medication		Strength	Frequency
Expected Length of Therapy	Quantity	Day Supply	Is this a continuation of therapy, how long has the patient been on this medication?

PLEASE CHECK ALL BOXES THAT APPLY:

☐ What condition is the drug being prescribed for? ICD code: _____
Diagnosis: _____

☐ Does the patient have a diagnosis of cancer? Yes ☐ No ☐

☐ Please list all medications the patient has tried specific to the diagnosis and specify below:
Therapeutic failure, including length of therapy for each drug: _____
Drug(s) contraindicated: _____
Adverse even (e.g., toxicity, allergy) for each drug: _____

☐ Is the request for a patient with one or more chronic conditions (e.g., psychiatric condition, Diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? If so, specify anticipated significant adverse event:
_____

☐ Has the condition been confirmed by diagnostic testing? If so, please provider diagnostic Test and date: _____
Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation:
_____

☐ Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If So, please provide dosage form: _____

☐ Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____

☐ Other: Please provide additional relevant information: _____
_____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICAITON. PLEASE COMPLETE CORRESPONDING SECTION FOR THE SPECIFIC DRUG/CLASS LISTED BELOW.

Antifungals/Antiemetic (5-HT3) Agents/Celebrex/Erectile Dysfunction Agents/Proton Pump Inhibitors/Protopic Provigil/Nuvigil/Stimulants/Tazorax/Tretinoin Products/Triptans

FOR ANY DRUGS/CLASS NOT LISTED, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES.

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor or delegate, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. 3729-3733.

Prescriber Signature	**Date**

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PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

☐ **ANTIFUNGALS: LAMISIL, SPORANOX, PENLAC, DIFLUCAN**

Does the patient have secondary medical risk factors? Please specify which risk factor(s): _____

If the patient has a diagnosis of Onychomycosis, does the infection involve the toenails, fingernails, or both? **Please circle**

If the diagnosis is Tinea corporis or Tinea cruris, does the patient require systemic therapy or have more extensive superficial infections? ☐ Yes ☐ No

☐ **ANTIEMETIC (5-HT3) AGENTS: (Ondansetron quantities of 12 or less per 30 days do not require a prior authorization)**

Is the patient receiving moderate to highly emetogenic chemotherapy? Monthly frequency: _____ ☐ Yes ☐ No

Is the patient receiving radiation therapy? Monthly frequency: _____ ☐ Yes ☐ No

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

Vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? ☐ Yes ☐ No

☐ **Celebrex:**

Is the patient at risk for a severe NSAID-related gastrointestinal (GI) adverse event (e.g., NSAID associated gastric ulcer, GI bleed? ☐ Yes ☐ No

☐ **ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL**

Does the patient require nitrate therapy on a regulator OR on an intermittent basis, or is the patient currently taking another ED medication? ☐ Yes ☐ No

If a diagnosis of erectile dysfunction, is it due to neurogenic etiology, vasculogenic etiology, psychogenic etiology or mixed etiology? **Please circle**.

Is it being used for symptomatic Benign Prostatic Hyperplasia (BPH)? ☐ Yes ☐ No

☐ **PROTON PUMP INHIBITORS:**

Does the patient have frequent and severe symptoms of GERD (e.g., heartburn, regurgitation)? ☐ Yes ☐ No

Does the patient have atypical symptoms or complications of GERD (e.g., dysphagia, hoarseness, erosive Esophagitis)? ☐ Yes ☐ No

☐ **PROTOPIC:**

Has the patient had a therapeutic failure of a topical corticosteroid? ☐ Yes ☐ No

☐ **PROVIGIL/NUVIGIL**:

If the patient has a diagnosis of Obstructive Sleep Apena, is the patient currently using a continuous positive airway pressure machine or other device? ☐ Yes ☐ No

☐ **STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA**

Is this a renewal therapy? ☐ Yes ☐ No

☐ **TAZORAC/TERTINOIN PRODUCTS:**

Has the patient tried and failed products from the following categories: Salicyclic Acid Prodcuts OR Benzoyl Peroxide products? ☐ Yes ☐ No

☐ **TRIPTANS:**

Is the patient currently using migraine prophylactic therapy (e.g., amitriptyline, propranolo, timolol)?	☐ Yes ☐ No