



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

AMWINS EGWP Medicare Prior Authorization Request

Phone: 855-693-3921

Fax back to: 866-650-3622

Retiree RxCare 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):

Drug Name and Strength:

Directions / SIG:

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard review timeframes (72 hours for initial requests or 7 days for appeals) may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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? <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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 quantity of medication that is being requested per 30 days?
Q5. What is the anticipated duration of therapy? <input type="checkbox"/> Less than one month <input type="checkbox"/> One to three months <input type="checkbox"/> Three months to one year <input type="checkbox"/> Lifetime
Q6. Please list all other medications the patient will be using concomitantly with the requested medication:



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

AMWINS EGWP Medicare Prior Authorization Request

Phone: 855-693-3921

Fax back to: 866-650-3622

Retiree RxCare 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:

Q7. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc):

Q8. Please indicate the patient's age:

Q9. Please indicate the prescriber's specialty below:

Q10. Please include any medical records, lab values, or corresponding chart notes to support the requested medication:

Q11. For OFF-LABEL indications, has the required information been submitted to meet the off-label administrative guideline criteria?

Yes

No

Prescriber Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document