

General Coverage Determination



Mail requests to: Coverage Determination & Exceptions
 PO Box 20002 Nashville, TN 37202
 Fax requests to: (866) 845-7267
 Request by phone: (877) 813-5595

FOR PROVIDER USE ONLY

| | |
|-----------------------------|----------------------------|
| Office Contact: | Provider Specialty: |
| Provider First Name: | Provider Last Name: |
| Provider Phone: | Provider Fax: |

Provider Address:

| | | |
|------------------------|--------------------|--------------------|
| License Number: | DEA Number: | NPI Number: |
|------------------------|--------------------|--------------------|

Customer Name: _____

Customer Address: _____

| | |
|---------------------------|------------|
| Customer Phone:(H) | (C) |
|---------------------------|------------|

| | |
|---------------------|-------------|
| Customer ID: | DOB: |
|---------------------|-------------|

| Rx Prescription Information | | | | |
|---------------------------------------|---|--|---|-----------------|
| Drug: | Dosage: | Frequency: | Quantity: | |
| | | | | |
| <input type="checkbox"/> Brand | <input type="checkbox"/> Generic | <input type="checkbox"/> New Medication | <input type="checkbox"/> Continuation (Provide Start Date) | Refills: |

List Diagnosis/ICD-10 code(s): _____

List all formulary alternatives the customer has tried, including the duration of therapy (start/end dates):

List adverse reaction, negative outcome, or intolerance customer has experienced with formulary alternatives:

Is the customer currently receiving dialysis? Yes No

If the request is for a transplant medication, was the transplant covered by Medicare? Yes No

If the transplant was covered by Medicare, please provide copy of the customer's Medicare card.

Please provide the date of the customer's transplant: _____

Is this drug to be used in a nebulizer? Yes No

Where will the nebulized medication be used? Home LTC Other: _____

Is the customer currently enrolled in Hospice? Yes No

Please provide Hospice disenrollment date: _____

Is the request for an inpatient that is awaiting discharge? Yes No

Failure to provide clinical documentation supporting rationale may result in this request being denied
Plan requires a 30 day trial and failure of at least 2 formulary alternatives when applicable

Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function.

Provider Signature: _____ Date: _____

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