Request for More Drug Per Dispensing: Coverage Review Request Form

35045

Your patient's benefit plan may limit the quantity of medication that can be obtained per member copayment. Before initiating a request for additional coverage, please note the following information:

- Additional quantity can be obtained through additional member copayment. The plan is not denying access to additional quantity.
- In many instances, higher drug strength dosage forms are subject to the identical quantity limits (**for example**, if the patient's plan limits the quantity per copay to 30 tablets, the patient could achieve more cost savings and possibly avoid the need for Prior Authorization if his/her medication were dosed 1 X 50mg tablet qd than if dosed 2 X 25mg tablets qd). If dosing using a higher strength tablet or capsule is appropriate, you may contact Medco at the toll free number listed below to confirm the quantity limits of higher strengths.

To initiate a coverage review for your patient, please fax us this completed form. Please note that the completion of this form does **not** guarantee benefit coverage. Our standard response time for a decision is 24 hours following receipt of all information needed.

If your request is urgent or if you have questions, contact us toll-free at 1 800 935-6103.

PATIENT INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Date of Birth: |__|__|/|__|__|/|__|__|__|__| Telephone: |__|__|__|-|__|__|__|-|__|__|__|__|

Medco Member ID Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|__|

MEDICATION (that requires a coverage review)

Drug name and strength: ______________________ Qty.: ______________________

Directions (SIG.): ____

Diagnosis: ____

PRESCRIBER INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|__|

SECURE Fax: |__|__|__| - |__|__|__| - |__|__|__|__| Telephone: |__|__|__| - |__|__|__| - |__|__|__|__|

Signature: ______________________________________ Date: ____________________

SECTION A: PLEASE ANSWER THE FOLLOWING QUESTIONS

☐ Yes	☐ No	Is a greater drug quantity necessary to achieve the prescribed dose?
☐ Yes	☐ No	Is a greater quantity of medication necessary to accommodate the frequency of use?
☐ Yes	☐ No	Is a greater drug quantity being requested to complete a course of treatment?
☐ Yes	☐ No	Has this patient had an inadequate response to once daily dosing?
☐ Yes	☐ No	Is this patient unable to tolerate once daily dosing?

FAX COMPLETED FORM TO 1 800 837-0959. (Please do **not** send with a cover sheet.)

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Location: Nevada (15) **Case Id: 9999999**

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