Excellus

REQUEST FOR DRUG EVALUATION

To be used for
Quantity Limits,
Coverage Determinations,
General Exceptions, **OR**
drugs without a unique P.A. form
Rx Benefit/Self-Administration

TO CALL THIS INFORMATION INTO THE PHARMACY HELP DESK DIRECTLY
PHONE #: 1(800) 499-1275
OR
FAX #: 1(800) 956-2397

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:
Servicing Prescriber NPI (if different from the ordering prescriber):	
Provide address of infusion location above for medication shipping:	

Medication/Medical and Dispensing Information					
1. **Medication** (HCPCS)	**Dose**	**Frequency**	**Height**	**Weight (lbs./kgs)**	**Procedure Code**

2. **Diagnosis/ICD-10**:

3. Is this request for a: ☐ New Start ***OR*** ☐ Continuation of Therapy (Recertification) Start date: _____

Questions/Indications for Medical Necessity

4. **Primary Diagnosis:** _____

5. Is the patient's diagnosis related to Worker's Compensation or a Motor Vehicle Accident? ☐ **Yes** ☐ **No**
*If yes, please submit to appropriate carrier.

6. Previous Therapies Attempted: ☐ **NONE or list previous medications below and outcomes**

Medication Name	Dose	Period of use	Outcome
		Start: End:	
		Start: End:	
		Start: End:	

7. **Explanation of Medical Necessity:**

_____

_____

_____

If preferred, a letter of medical necessity may be attached to this form and submitted with the appropriate patient information

*Prescriber Signature: _____ Date: _____

I certify the above is true and accurate to the best of my knowledge.

URGENT REQUESTS ONLY: 1(800) 208-4050 (fax)