Excellus

Drug Evaluation Request Form

End Stage Renal Disease (ESRD)
Medicare-D

Complete this form and fax to:
Fax #: 1-800-956-2397
Urgent Request Only Fax: 1-800-208-4050

For Assistance Completing this form:
Pharmacy Help Desk Fax: 1-800-956-2397
Phone: 1-800-499-1275

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:

Medication/Medical and Dispensing Information

1. **Medication (HCPCS)**	**Dose**	**Frequency**	**Height**	**Weight (lbs. or kg)**	**Procedure Code**

Questions/Indications for Medical Necessity	
2. Is the patient on dialysis for ESRD? *If **NO**, skip to question 6	☐ **Yes** ☐ **No**
3. Is the prescribing physician a nephrologist or a mid-level practitioner specializing in nephrology? *If **NO**, no further response is required. *If **YES**, you must answer question 4 & 5 below	☐ **Yes** ☐ **No**
4. Does the prescribing physician receive a monthly capitation payment to manage ESRD patient's care?	☐ **Yes** ☐ **No**
5. Is the prescribed drug being used for an ESRD related condition? *If **NO**, provide the diagnosis/ICD-10: _____	☐ **Yes** ☐ **No**
6. Patient **NOT** Receiving Dialysis	
1. Did the patient receive a transplant? *If **YES**, provide the date: _____	☐ **Yes** ☐ **No**
2. Did the patient elect to stop dialysis? *If **YES**, provide the date: _____	☐ **Yes** ☐ **No**
3. Other: (please explain)	
*If preferred, a letter of medical necessity may be attached to this form and submitted with the appropriate patient information.	

***ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.**

*Prescriber Signature: _____ Date: _____

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