Future Scripts has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit https://www.futurescripts.com/ to begin using this free service.

Please complete ALL information below and fax your request to 1-888-671-5285

Coverage Determination Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

- ❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs.
- ❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan (**Note:** specific clinical questions may apply. Specific drug form may be available).
- ❑ **Step Therapy**- Request is for an exception to the requirement to try another drug first.
- ❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.
  Quantity per DAY requested? _____
- ❑ **Tier Exception (Lower Copay) request**- Request for a lower copayment because there are other drugs that treat the same condition at the lower copayment. **Note:** Does not apply to the Specialty tier and is limited to the initial coverage phase.

What is the patient's diagnosis for the medication being requested?

_____

ICD-10 Code(s): _____

What medication(s) has the patient tried and failed OR have contraindications to? (Specify all)

Please list all medication(s) that treat the same condition that would not be as effective for the patient as the requested medication or would cause adverse effects:

Use of High Risk Medications in the elderly (applies to patients ≥ 65 years only). ***Examples include estrogens, sulfonylureas (e.g., glyburide), hypnotics (e.g., zolpidem), muscle relaxants (e.g., cyclobenzaprine).***

Has a risk versus benefit assessment been completed for this request of a high risk medication (HRM) in an elderly patient? ❑ **Yes** ❑ **No**

Coverage Determination Request Form (Page 2 of 2)

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Quantity limit requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:_____

FOR OPIOID THERAPY that exceeds 90 morphine milligram equivalent (MME)

Does the provider attest that opioid therapy above 90 MME per day is medically required? ❑ **Yes** ❑ **No**

Opioid Requests exceeding 7 Day Supply Limit:

Does the provider attest that in his/her clinical judgment, the requested day supply exceeding the current 7 day supply limit is medically necessary? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.