COVERAGE DETERMINATION REQUEST FORM

Slate Rx

Non-formulary Exception Request

Phone: 833-320-1824 Fax back to: 866-351-1617

SlateRx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions, sign and fax this form to the number listed above.

Please note any information left blank or illegible may delay the review process

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date Of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip: ,	City, State, Zip: ,	
Primary Phone:	Specialty:	

☐ Standard ☐ Expedited / Urgent

Drug Name and Strength:

Directions / SIG:

Q1. Please indicate the patient's diagnosis for the requested medication.
(When requested medication is for off-label use, including but not limited to indication, age, or dosage, please submit two (2) evidence-based clinical trials or guidelines as supporting evidence of safety and efficacy for use of the medication for this diagnosis.)

Q2. Please provide all ICD-10 Code(s) relevant to the medication request
(*Note: Medical records / chart notes documenting the patient's diagnosis MUST be submitted.)

Q3. Please indicate the quantity, day supply, and directions for the requested medication. *

Q4. Is the request for initial or continuing therapy? (If continuation of therapy, please include the start date - MM/YYYY)

☐ Initial therapy ☐ Continuing therapy _____

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EOC ID: «EOC ID»

«Product Name»

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Patient Name:	**Prescriber Name:**

Q5. Has the patient tried and failed at least two (2) formulary alternatives, in at least 2 different classifications when available, of at least 90 days in duration for each alternative?

☐ Yes ☐ No ☐ Unknown

Q6. Please indicate all formulary alternatives that have been tried/failed, the duration of therapy, and the timeframe of the failure pertaining to this diagnosis. If the answer to previous question is not applicable (N/A), please provide reason below. (Submit chart notes supporting the alternatives tried and failed.)

Q7. Does the patient have a contraindication or intolerance to any or ALL formulary alternative medications based on the member's diagnosis, medical conditions, or other medication therapies?

☐ Yes ☐ No

Q8. If all formulary alternatives are contraindicated or the patient has a documented intolerance, please provide the name of the medication(s), the specific reason why each alternative is contraindicated, and/or the adverse outcome resulting from the use of each alternative.

Q9. For combination medication requests, provide the clinical reason supported by chart notes why the member is unable to take the active ingredients individually.

Q10. For long acting formulation requests, provide a clinical reason supported by chart notes why the patient is unable to use the formulary immediate-release formulation.

Prescriber Signature: _____ Date: _____