

COVERAGE DETERMINATION REQUEST FORM

Step Therapy Exception

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 being treated by the requested medication.		
Q2. Is the request for initial or continuing therap start date - MM/YYYY)	y? (If continuation of the	erapy, please include the
☐ Initial therapy	☐ Continuing therapy	
Q3. Please provide the specific alternative med patient has tried and failed.	ications name and stren	gth, including dates, the
Q4. If the member has not previously tried and alternative, please indicate below why the mem therapy.	•	
Prescriber Signature:		Date:

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