**SENIOR WHOLE HEALTH**
**PRESCRIPTION DRUG COVERAGE DETERMINATION FORM**
Copies of this form and additional information available at [http://www.seniorwholehealth.com](http://www.seniorwholehealth.com)

**THIS FORM MAY BE SENT TO US BY MAIL OR BY FAX**

**Address:** 58 Charles Street Cambridge, MA 02141  **Fax:** 1-888-251-7823

You may also ask for a coverage determination by phone at **1-855-818-4876**. To avoid unnecessary delays,

**PLEASE ENSURE THAT YOU COMPLETE THE FORM IN ITS ENTIRETY AND PRINT NEATLY.**

Who May Make a Request: The member and prescriber (on your behalf) may ask us for a coverage determination. If another individual (such as a family member or friend) makes a request for you, that individual must be your authorized representative. Contact us to learn how to name an authorized representative.

REQUESTING PARTY:  
☐ PREScriber  ☐ MEMBer  ☐ MEMBER’S AUTHORIZED REPRESENTATIVE

*Please note that a member’s authorized representative must have adequate documentation on file, such as an active Appointment of Representative Form (AOR Form), to avoid delays.*

**ENROLLEE INFORMATION**

<table>
<thead>
<tr>
<th>Member’s Name:</th>
<th>Member Authorized Representative Name (if applicable):</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Weight:</td>
<td>Height:</td>
<td>Enrollee’s SWH Member ID #:</td>
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**DRUG BEING PRESCRIBED**

<table>
<thead>
<tr>
<th>Name of Drug:</th>
<th>Strength:</th>
<th>Quantity:</th>
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<tbody>
<tr>
<td>Route:</td>
<td>Directions:</td>
<td>Duration of Therapy:</td>
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**PRESCRIBER INFORMATION**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Specialty:</th>
<th>Office Contact:</th>
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<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
<td>State:</td>
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<tr>
<td>Office Phone:</td>
<td>Fax:</td>
<td>NPI:</td>
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**RATIONALE FOR REQUEST**

☐ Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change  
☐ Medical need for different dosage form and/or higher dosage

Select one:  
☐ Generic substitution authorized  ☐ Dispense as written

Rationale for need for a formulary non-preferred product / non-formulary product  
Current relevant diagnosis:

Please provide:

Please provide ICD-10 and description:

Relevant lab results, scans, x-rays, etc., that support use of therapy (Please attach copy of most recent labs).

Drug Allergies

Please provide:

Please Provide:
Covered alternatives if applicable:

Please list alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure.

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<tr>
<th>Drug &amp; Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Start Date</th>
<th>Stop Date</th>
<th>Outcome/Reason for failure</th>
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URGENT REQUEST CHECK

☐ If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber’s support for an expedited request, we will decide if your case requires a fast decision.

Additional relevant clinical information:
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
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Signature: _______________________________ Date: __________________

IMPORTANT:
Please provide additional relevant clinical information that will help us to facilitate processing of your request, including but not limited to: MUST BE INCLUDED TO AVOID DELAYS

Commonly Requested Medications:

- **Lidocaine**: Indication, ICD-10 code (e.g. Postherpetic neuralgia)
- **Hydroxyzine**: Indication, ICD-10 code, Trials of previous drugs/outcomes (e.g. SSRIs, SNRIs), letter confirming doctor has assessed risk vs. benefits and wants to continue with therapy.
- **Cyclobenzaprine**: Trials of previous drugs/outcomes, letter confirming doctor has assessed risk vs. benefits and wants to continue with therapy.
- **Amitriptyline**: Trials of previous drugs/outcomes (e.g. depression: SSRIs, SNRIs; pain: Cymbalta, gabapentin, Lyrica)
- **Prolia**: Bisphosphonate trial/duration, BMD score, T-score: lumbar spine, total hip or femoral neck, kidney function (CrCl)
- **Harvoni/Epclusa**: Genotype, viral load, AST/ALT, results of liver biopsy, prescribed based on the most current AASLD guidelines

H2224_2019_71376_C Approved 1/4/19
- **Clonazepam/Diazepam/Lorazepam**: Trials of previous drugs/outcomes, letter confirming doctor has assessed risk vs. benefits and wants to continue with therapy.

- **Procrit**: CBC, Hgb, Hct, iron study (inc. ferritin and transferrin saturation), kidney function (CrCl, dialysis)

- **Daliresp**: COPD stage (GOLD guidelines), trials of previous drugs/outcomes, exacerbation hx, chronic bronchitis

- **Colcrys**: Indication, previous drugs/outcomes (e.g. Mitigare)

- **Zolpidem**: Indications, trials of previous drugs/outcomes (e.g. Rozerem)

- **Gabapentin**: Indication, ICD-10 code (e.g. Fibromyalgia)

- **Levemir**: Indication, ICD-10 code, Trials of previous drugs/outcomes (e.g. Lantus)

- **Restasis**: Indication, ICD-10 code, Trials of previous drugs/outcomes (e.g. Xiidra)

- **Long Acting Opioids**: diagnosis, prescription for short acting opioids, letter confirming: previous trial of opioids, non-opioid therapy is optimized, MD has checked PMP, risks of opioids discussed with patient, and treatment plan is assessed at regular intervals