COVERAGE DETERMINATION REQUEST FORM

Please complete form in full. Incomplete or ineligible sections will result in processing delays. If you require assistance in completing this form, please contact CastiaRx at 1-800-546-5677. Requests are normally processed within 72 hours from the time complete information is received at CastiaRx. All requests are effective from the date received in office. Requests received in arrears will apply to the next claim and not applied retrospectively.

Patient Information:

SECTION ONE

PATIENT NAME:	
DATE OF BIRTH:	**IDENTIFICATION OR ID #:**
PLAN NAME:	**PLAN NUMBER:**

Healthcare Provider: Please complete SECTION TWO. Please attach a separate letter if more space is required.

SECTION TWO

REASON FOR REQUEST:

☐ Cover a non-formulary medication
☐ Over-ride the quantity limitation on a medication
☐ Other *(Please indicate reason)*:
☐ Cover a medication that requires step therapy trials
☐ Cover a medication that requires pre-certification

MEDICATION NAME, STRENGTH, AND SIG:	**START DATE OF THERAPY**:

SPECIALTY MEDICATIONS THAT ARE APPROVED WILL BE DIRECTED TO THE CONTRACTED SPECIALTY PHARMACY PROVIDER. THE SPECIALTY PHARMACY WILL BE NOTIFIED OF AUTHORIZATION APPROVALS AND WILL OUTREACH TO THE PROVIDER AND THE PATIENT.

PAST FAILURES AND DOCUMENTATION OF REASON FOR PAST FAILURES: *(Therapeutically dosed over the counter products may be included)*

Trial #1 _____ **Dates of Therapy:** Start ____/____/_____ Discontinue ____/____/_____
(Drug name, strength, and sig)
Reason for Discontinuation:_____

Trial #2 _____ **Dates of Therapy:** Start ____/____/_____ Discontinue ____/____/_____
(Drug name, strength, and sig)
Reason for Discontinuation:_____

Trial #3 _____ **Dates of Therapy:** Start ____/____/_____ Discontinue ____/____/_____
(Drug name, strength, and sig)
Reason for Discontinuation:_____

PLEASE LIST ANY CONTRAINDICATIONS TO FORMULARY, ALTERNATIVE, OR GENERIC MEDICATIONS:

DIAGNOSIS OR CONCURRENT DISEASE STATES:

SIGNIFICANT LAB VALUES:

MEDICAL NECESSITY REASON OR OFF-LABEL USE DOCUMENTATION[1]:

QUANTITY LIMIT EXCEPTION: *(Please provide specific dosing schedule and tapering information – authorization may only be approved for 6 months)*

I understand that the False Claims Acts, 31 USC sections 3729-3733, prohibits knowingly and willfully making or causing to be made any false statement or representation of material fact[1] in any application or claim for benefits or payment under a federal healthcare program, including Medicare or Medicaid. I certify that the information provided above for this member is consistent with the patient's medical records.

PRESCRIBER'S PRINTED NAME:	**PRESCRIBER'S SIGNATURE:**	
DEA/LICENSING NUMBER:	**OFFICE PHONE:** ( )	**FAX:** ( )
ADDRESS:		
CITY:	**STATE:**	**ZIP:**

PLEASE FAX THIS REQUEST FORM TO CASTIARX AT 1-866-632-7946.

[1] Provision of false information: Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services.