# General Coverage Determination

Mail requests to: Coverage Determination & Exceptions
PO Box 20002 Nashville, TN 37202
Fax requests to: (866) 845-7267
Request by phone: (888) 886-1989

## FOR PROVIDER USE ONLY

| | |
|---|---|
| **Office Contact:** | **Provider Specialty:** |
| **Provider First Name:** | **Provider Last Name:** |
| **Provider Phone:** | **Provider Fax:** |

**Provider Address:**

| | | |
|---|---|---|
| **License Number:** | **DEA Number:** | **NPI Number:** |

**Customer Name:**

**Customer Address:**

| | |
|---|---|
| **Customer Phone:(H)** | **(C)** |
| **Customer ID:** | **DOB:** |

| **Rx** | | **Prescription Information** | | |
|---|---|---|---|---|
| **Drug:** | | **Dosage:** | **Frequency:** | **Quantity:** |
| ☐ **Brand** | ☐ **Generic** | ☐ **New Medication** | ☐ **Continuation (Provide Start Date)** | **Refills:** |

List Diagnosis/ICD-10 code(s): ______________________________

List all formulary alternatives the customer has tried, including the duration of therapy (start/end dates):

List adverse reaction, negative outcome, or intolerance customer has experienced with formulary alternatives:

Is the customer currently receiving dialysis? Yes No

If the request is for a transplant medication, was the transplant covered by Medicare? Yes No

**If the transplant was covered by Medicare, please provide copy of the customer's Medicare card.**

Please provide the date of the customer's transplant: ______________________________

INT_16_40865

Is this drug to be used in a nebulizer? Yes No

Where will the nebulized medication be used? Home LTC Other: ____________

Is the customer currently enrolled in Hospice? Yes No

Please provide Hospice disenrollment date: ____________

Is the request for an inpatient that is awaiting discharge? Yes No

**Failure to provide clinical documentation supporting rationale may result in this request being denied**

**Plan requires a 30 day trial and failure of at least 2 formulary alternatives when applicable**

☐ ***Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function.***

**Provider Signature:** **Date:**

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