Medication being requested: ☐ Clinical Review Form

This form allows the pharmacy benefit manager to review the use of the medication for coverage. The submission of this form does not guarantee approval and coverage of the medication requested. ***Documentation is required****.*

Confidentiality Notice: This document contains confidential protected health information and intended for the recipient below. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the destruction of these documents.

Patient Information		***Prescriber Information***	
Patient Name:	Patient ID:	Prescriber Name:	Specialty:
Patient DOB:	Client ID:	Phone:	Fax:
Date:	Request ID:	NPI:	DEA:
		Office Address:	

Prescriber use only:				
Strength:	Quantity:	Days Supply:	Expected Duration of Therapy:	Wt:_____ KG / LB (circle) Ht:_____ CM / IN (circle)
Directions for use:				
Diagnosis:				List Diagnosis Codes:

Answer Section Below for All Requests:

Is the requested medication being used for and FDA approved indication and dose/quantity? ☐ YES ☐ NO
If NO, provide rationale and clinical literature supporting use: _____

Is the medication being administered by or under the guidance of a healthcare PROVIDER and/or in a physician's office? ☐ PROVIDER ☐ PATIENT

Is the medication being prescribed by, or in consultation with a specialist? ☐ YES ☐ NO

Does the patient have hepatic or renal disfunction? ☐ YES ☐ NO
If YES, specify: _____

Is the requested medication a NEW or EXISTING therapy? ☐ NEW ☐ EXISTING
If EXISTING therapy, how long has the patient been on the requested medication?_____

Please list ALL medications the patient has tried for this diagnosis and specify reason.

Medication and strength	Reason for failure / Contraindication	Trial date
_____	_____	_____
_____	_____	_____
_____	_____	_____

****All requests require documentation**. Please submit chart notes and relevant clinical information including lab values**

CURRENT THERAPY: Medication(s) dose(s), duration(s) and date(s)	**TRIALED THERAPY:** Medication(s) dose(s), duration(s) and date(s)

Additional Relevant Clinical Information:

Attestation: I attest the information and supporting documentation provided is accurate, complete, and true to the best of my knowledge.

Prescriber Signature: _____ Date: _____

Once complete, fax this form, along with supporting documentation (chart notes, labs, etc.) back to EmpiRx Health at (___)-___-____. Completed forms are required for full review. For questions please call (___)-___-____.

This form is based on standard criteria and may not be applicable to all patients and plans and additional information or clarification may be required to evaluate requests. This form is intended for the purpose of obtaining new or continued prescription treatment for the above member.