REQUEST FOR PRESCRIPTION DRUG COVERAGE DETERMINATION

COMPLETE REQUIRED CRITERIA AND FAX TO COLORADO ACCESS 855-668-8551			
Date:		Prescriber Name:	
Patient Name:		Prescriber NPI #:	
CO Access ID #:		Prescriber Phone:	
Date of Birth:		Prescriber Fax:	

REQUEST TYPE:	☐ 1. Quantity Limit Increase	☐ 2. Prior Authorization	☐ 3. High Dose
	☐ 4. Age Specific	☐ 5. Step Therapy	☐ 6. Non-Formulary

1. Quantity Limit Increase: Dose prescribed exceeds quantity limits. Indicate diagnosis/clinical rationale why the covered quantity and/or dosing limits are insufficient.

2. Prior Authorization: This medication has a defined set of criteria that must be met before coverage is granted. Please see our website for criteria.

3. High Dose Alert: Dose prescribed is flagged as >2.5 times the recommend maximum daily dose. Please provide monitoring criteria and/or clinical rationale for exceeding the recommended dose.

4. Age Specific: Drug prescribed may not be recommended for age and may be considered a high risk medication in members 65 years of age and older. Indicate diagnosis and clinical rationale for use.

5. Step Therapy: Preferred step therapy drugs are inappropriate or have been ineffective for treatment. Please submit clinical documentation with request.

6. Non-Formulary Medication: All formulary alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table. Formulary documents available at www.coaccess.com.

REQUESTED DRUG INFORMATION		DIAGNOSIS / INDICATION / REASON FOR USE
MEDICATION		
STRENGTH		
FREQUENCY		
QUANTITY		

Has the patient been started on this medication? ☐ Yes ☐ No

If yes, please provide the start date: _____

☐ Check this box if patient is stable on the current drug and the physician feels there is high risk of significant adverse clinical outcome(s) with medication change. Please specify anticipated adverse clinical outcome(s):

_____

Formulary Alternative(s)	Max Dose Used	Dosing Frequency	Trial Dates	Describe Specific and Significant Side Effects and/or Ineffectiveness

If complex medical management exists, supply supporting documentation with this request.

Prescriber's Signature: _____ Date: _____