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**Pharmacy Department**  
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## Commercial Pharmacy Coverage Determination Form

Patient Information:	Prescriber Information:
Patient Name:	Prescriber:
Member ID #:	Office Phone #:
Date of Birth:	Office Fax #:
Phone #:	NPI #:
Address:	Office Contact:

Medication and Diagnosis Information:	
Medication: _____	Strength: _____
Dispensed from: <input type="checkbox"/> Provider's Stock (Buy & Bill)	<input type="checkbox"/> Pharmacy's Stock
Must check one: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Route: _____
Frequency: _____	Quantity: _____
Diagnosis: _____	
If expedited review is needed, please provide rationale: _____	
_____	
Alternate Drug(s) Previously Tried or Contraindicated:	
Drug:	Date(s) Used: Outcome:
Drug:	Date(s) Used: Outcome:
Drug:	Date(s) Used: Outcome:
<input type="checkbox"/> Indicate if request is due to drug supply shortage.	

Rationale for Request: (Please attach relevant labs and clinic notes)

Prescriber or Authorized Representative Signature:
Signature: _____ Date: _____
Prescriber Specialty: _____

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