



Inter Valley Health Plan  
For health. Not for profit.

# Inter Valley Health Plan

300 S. Park Ave., Pomona, CA 91769-6002

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## Pharmacy Coverage Determination Request Form

This form cannot be used to request:

- Biotech or other specialty drugs for which drug-specific forms are required. [See < [www.ivhp.com](http://www.ivhp.com).>] OR [See links to Plan website at [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04\\_Formulary.asp](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp)]

Patient Information		Prescriber Information	
<b>Patient Name:</b>		<b>Prescriber Name</b>	
Member ID:		NPI#	Contact:
Mailing Address:		Mailing Address:	
City:	ZIP:	City:	ZIP:
Phone No.:		Office Phone No.	
Sex (circle) M F DOB:		Fax No.	
Diagnosis and Medical Information			
Medication:		Strength and Route of Administration	Frequency:
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:	QTY:
Height/Weight	Drug Allergies:		Diagnosis:
Prescriber's Signature:		Date:	
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure). ➤ Specify below: 1) drug(s) contraindicated or tried; 2) adverse outcome for each; 3) if therapeutic failure, length of therapy on each drug(s). <input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. ➤ Specify below: Anticipated significant adverse clinical outcome. <input type="checkbox"/> Medical need for different dosage form and/or higher dosage. ➤ Specify below: 1) dosage form(s) and/or dosage(s) tried; 2) explain medical reason. <input type="checkbox"/> Request for formulary tier exception. ➤ Specify below: 1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not was effective as requested drug; 2) if therapeutic failure, length of therapy on each drug and adverse outcome; 3) if not as effective, length of therapy on each drug and outcome. <input type="checkbox"/> Other: _____ Explain below <b>REQUIRED EXPLANATION:</b> _____ _____ _____			
Inter Valley Health Plan Use Only			
<b>STATUS:</b>		<b>Approved from</b>	<b>through</b>
<input type="checkbox"/> Approved		COMMENTS:	
<input type="checkbox"/> Modified			
<input type="checkbox"/> Denied			
Signature:		Date:	