univera HEALTHCARE

# Drug Evaluation Request Form

**End Stage Renal Disease (ESRD)**
**Medicare-D**

**Complete this form and fax to:**
**Fax #:** 1-800-956-2397
**Urgent Request Only Fax**: 1-800-208-4050

**For Assistance Completing this form:**
**Pharmacy Help Desk Fax**: 1-800-956-2397
**Phone:** 1-800-499-1275

**Complete ALL the following Patient/Prescriber Information: (Please Print)**

| **Patient Information** | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | | Patient Phone #: ( ) | | |
| Patient ID # | | | Patient Birthdate: | | |
| List Patient Allergy (If Any) | | | | | |
| **Prescriber Information** | | | | | |
| Prescriber Name: | | | Prescriber Specialty: | | |
| Prescriber Address: | | | | | |
| Prescriber Phone #: | | | Prescriber Fax #: | | |
| Prescriber NPI #: | | | Office Contact: | | Extension: |
| **Medication/Medical and Dispensing Information** | | | | | |
| 1. **Medication (HCPCS)** | **Dose** | **Frequency** | **Height** | **Weight (lbs. or kg)** | **Procedure Code** |
| | | | | | |
| | | | | | |

| **Questions/Indications for Medical Necessity** | |
|---|---|
| 2. Is the patient on dialysis for ESRD? *If **NO**, skip to question 6 | ☐ **Yes** ☐ **No** |
| 3. Is the prescribing physician a nephrologist or a mid-level practitioner specializing in nephrology?<br>*If **NO**, no further response is required. *If **YES**, you must answer question 4 & 5 below | ☐ **Yes** ☐ **No** |
| 4. Does the prescribing physician receive a monthly capitation payment to manage ESRD patient's care? | ☐ **Yes** ☐ **No** |
| 5. Is the prescribed drug being used for an ESRD related condition?<br>*If **NO**, provide the diagnosis/ICD-10: _____ | ☐ **Yes** ☐ **No** |
| 6. Patient **NOT** Receiving Dialysis | |
| 1. Did the patient receive a transplant?<br>*If **YES**, provide the date: _____ | ☐ **Yes** ☐ **No** |
| 2. Did the patient elect to stop dialysis?<br>*If **YES**, provide the date: _____ | ☐ **Yes** ☐ **No** |
| 3. Other: (please explain) | |
| *If preferred, a letter of medical necessity may be attached to this form and submitted with the appropriate patient information. | |

***ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.**

*Prescriber Signature: _____ Date: _____

I certify the above information is true and accurate to the best of my knowledge.