Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

MEDICARE D ESRD

REQUEST FOR DRUG EVALUATION

FAX: 1-800-956-2397

Please complete all of the following Patient/Physician Information:

Patient Name: (Please Print)	
FLRx Patient ID number:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Phone #: ( )	**MD FAX #: ( )**
MD DEA #:	**MD NPI #:**

1. Requested Drug(s) Name/Dose/Directions for Use:

2. Is the patient on dialysis for ESRD? (If *NO*, please skip to question 6) □ YES □ NO

3. Is the prescribing physician a nephrologist or a mid-level practitioner specializing in nephrology? (If *NO*, no further response is required. If YES, you must answer questions 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? □ YES □ NO

If NO, please provide the diagnosis _____

6. If the patient is *NOT* receiving dialysis:

1. **Did the patient receive a transplant?** □ YES □ NO **Date:**_____
2. **Did the patient elect to stop dialysis?** □ YES □ NO **Date:**_____
3. **Other** (please explain)

_____

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I certify that the above information is true and accurate to the best of my knowledge. To avoid processing delays, please add your electronic signature below or print this document and provide your handwritten signature.

Prescriber Signature_____**Date**_____

If preferred, a letter of medical necessity may be attached to this form and submitted with the appropriate patient information.

Please call for assistance in completing this form at:
Pharmacy Help Desk at 1-800-956-2397 or call 1-800-363-4658
Urgent Requests Only: 1-800-208-4050 (fax)

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