IL COPAY WAIVER

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For gender identity disorder (GID), gender dysphoria, or gender incongruence requests:

1. Is the requested agent hormonal therapy being used for GID, gender dysphoria, or gender incongruence requests? ..... ☐ Yes ☐ No
2. Is the patient 18 years of age or older? ..... ☐ Yes ☐ No
   a. If the patient will be receiving treatment in Florida, then their written informed consent was provided from an in-person visit with a physician ..... ☐ Yes ☐ No
   b. If the patient will be receiving treatment in Alabama, then they are 19 years of age or older ..... ☐ Yes ☐ No
3. Is the patient 17 years of age or younger? ..... ☐ Yes ☐ No
   a. If the patient is new to therapy, the patient will NOT be receiving treatment in Alabama, Oklahoma, Florida, Indiana, Iowa, Kentucky, Louisiana, Mississippi, North Carolina, North Dakota, South Dakota, or Tennessee ... ☐ Yes ☐ No
   b. If the patient is continuing therapy:
      i. The patient is NOT receiving treatment in Alabama, Oklahoma, Indiana, Iowa, Mississippi, or South Dakota ..... ☐ Yes ☐ No
      ii. The patient is continuing treatment in Florida and treatment began prior to 05/17/2023 ..... ☐ Yes ☐ No
         1. The patients written informed consent was provided from an in-person visit with a physician ..... ☐ Yes ☐ No
      iii. The patient is continuing treatment in Kentucky and the provider has documented that immediately terminating the minor's use of the treatment would cause harm to the patient, and the provider has instituted a period of time where treatment is systematically reduced ..... ☐ Yes ☐ No
      iv. The patient is continuing treatment in Louisiana and treatment began prior to 0/1/01/2024 and the provider has documented that immediately terminating the minor's use of the treatment would cause harm to the patient, and the provider has instituted a period of time where treatment is systematically reduced ending 12/31/2024 ..... ☐ Yes ☐ No
      v. The patient is continuing treatment in North Carolina and treatment began prior to 08/01/2023 ..... ☐ Yes ☐ No
      vi. The patient is continuing treatment in North Dakota and treatment began prior to 04/21/2023 ☐ Yes ☐ No
      vii. The patient is continuing treatment in Tennessee and treatment began prior to 07/01/2023 and is ending prior to 03/31/2024 ..... ☐ Yes ☐ No

For pregnancy termination requests:

4. Is the requested agent being used to terminate pregnancy? ..... ☐ Yes ☐ No
5. ****Please note, if the patient will be receiving treatment in one of the listed states, medical records are required for review**** The patient will NOT be receiving treatment in Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, Wyoming ..... ☐ Yes ☐ No

Other:

6. Is the requested agent being used for human immunodeficiency virus pre-exposure prophylaxis? ..... ☐ Yes ☐ No
7. Is the requested agent being used for human immunodeficiency virus post-exposure prophylaxis? ..... ☐ Yes ☐ No

For all requests:

8. What is the patient's weight? _____ (kg) What is the patient's height? _____ (cm)
9. Is the patient currently being treated with the requested agent? ..... ☐ Yes ☐ No
10. Does the patient have any FDA labeled contraindications to the requested agent? ..... ☐ Yes ☐ No