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REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations)

Please print this form and provide to your prescribing physician. Your Physican's office can submit this form via fax (877) 837-5922

<u>Note</u>: For immediate service your Physicians office can call for a coverage determination to (800) 417-8164 (option 1)

Enrollee Information

Enrollee's Name ____________________

Enrollee's Date of Birth ____________________

Enrollee's Medicare Number ____________________

Enrollee's Part D Plan ID Number ____________________

Enrollee Address City State Zip Code ____________________

Phone (   ) ____________________

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Prescribing Physician's Information

Name ____________________

Medical Specialty ____________________

Address ____________________ City ____________ State ____________ Zip Code ____________

Work Phone (   ) ____________

Fax (   ) ____________

Office Contact Person ____________

Physician Signature ____________________

Date ____________

Please Note:

If the information is NOT filled in completely, correctly or legibly, the Coverage determination review **<u>will be delayed</u>**.

Type of Coverage Determination Request

Prescribing Physician: Please fill out below Physician supporting statement below.

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*

☐ I request prior authorization for the drug my doctor has prescribed.*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

***NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs**.

Physician supporting statement (Diagnosis-Indication-Medical History- Other Medications/Therapies Tried: *Attach any supporting documents)*:

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If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

☐ I need an expedited coverage determination (attach physician's supporting statement, if applicable)