

<Plan Logo>

<Plan Mailing Address>

<Plan Phone Number>

<Plan Fax Number>

Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- **Biotech or other specialty drugs for which drug-specific forms are required. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]**

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID#:			NPI# (if available):		
Address:			Address:		
City:		State:	City:		State:
Home Phone:		Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle):	M	F	DOB:		Contact Person:

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:

**Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION**

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, 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);

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

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

Request for formulary tier exception
 ➔ Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as 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

Other: _____ ➔ Explain below

REQUIRED EXPLANATION: _____

Request for Expedited Review

REQUEST FOR EXPEDITED REVIEW [24 HOURS]
 ➔ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION