

<p style="text-align: center;">Model Form Instructions Request for a Medicare Prescription Drug Coverage Determination</p>
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Purpose of Model Form

This model form was developed in response to requests from outside parties to provide guidance to enrollees on requesting coverage determinations (including exception requests) from Part D plans. It is intended to provide basic information to enrollees on how to ask for a coverage determination from a Medicare drug plan.

Under the Medicare Part D prescription drug benefit program, a Part D plan enrollee can request a coverage determination, including a request for a tiering or formulary exception. A request can also be made on behalf of the enrollee by the enrollee's appointed representative or the enrollee's prescribing physician. A request for a standard coverage determination is generally made in writing, but a plan can choose to accept oral requests. A request for an expedited coverage determination can be made orally or in writing. An enrollee, the enrollee's appointed representative, or the enrollee's prescribing physician may submit a written request for a coverage determination in any format.

Use of Model Form

Use of this model form is **optional**. The **format and content of this model form may be changed** by any person or entity (e.g., enrollee, Part D plan) that uses it. Enrollees, appointed representatives, and prescribing physicians who wish to use this form should contact the enrollee's Medicare drug plan to find out if the plan uses a different form. **If this model form is used, the Medicare drug plan may require additional information or documentation to support the enrollee's request.** A plan that chooses to use this model form should modify the form, as necessary, to include information on relevant plan policies and procedures.

<p style="text-align: center;">Use of this model form is optional and its content may be changed.</p>
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Plan Name _____

Phone # _____

Fax # _____

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

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.