



Medicare Part D Medication Coverage Determination Request Form

This form cannot be used to request Medicare excluded/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); or biotech or other specialty drugs for which drug-specific forms are required (see www.passportadvantage.org).

For Standard Requests [72 Hours] FAX: (866) 369-6038 Mail: Prior Authorization Dept. 200 Stevens Drive, Philadelphia, PA 19113	Request for Expedited Review [24 Hours] Check below and FAX to (866) 533-5491 <input type="checkbox"/> By checking this box and signing below, 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.	HOSPITAL DISCHARGE Request Check below and FAX to (866) 533-5491 <input type="checkbox"/> By checking this box and signing below, I certify this request is for a hospital discharge and have referred to the attached <i>Hospital Discharge Supplement</i> .
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Patient Information			
Patient Name:		Date of Birth:	
Member ID #:	Home Telephone:	Sex (circle): Male Female	
Address:	City:	State:	Zip:

Provider Information	
Prescriber Name/Specialty:	NPI: (if applicable)
Address:	City, State, Zip:
Facility Name: (if related to a discharge)	Discharge Planner or Contact Name/Telephone:
Office Telephone/Fax:	

Diagnosis & Medical Information for Requested Medication		
Name of Medication:	Strength and Route of Administration:	Dosage Form/Frequency:
<input type="checkbox"/> New Prescription OR <input type="checkbox"/> Date Therapy Initiated: ____ / ____ / ____	Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis/ICD-9 Code:
Is the requested drug a previously prior authorized therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, is request a dose adjustment? <input type="checkbox"/> YES <input type="checkbox"/> NO
Prescriber Signature:		Date:

**Rationale for Exception Request or Prior Authorization. Check applicable rationale(s) only.
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION.**

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e. toxicity, allergy, or therapeutic failure). **‡ Specify below (1) drug(s) contraindicated or tried, (2) the adverse outcome for each, (3) if therapeutic failure, length of therapy on each drug.**
- Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk for 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; OR (2) explain medical reason.**
Not Applicable to Passport Advantage: Request for formulary tier exception. **‡ Specify below:** (1) Formulary or preferred drug(s) 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 anticipated benefit/outcome of requested drug.
- Other, please explain below.
EXPLANATION REQUIRED: _____

Check here if lab or medical results are attached.

Previous Therapy:	Strength:	Directions for Use:	Outcome/Effects:	Date Treatment Started:	Date Treatment Ended:

For assistance, pharmacies should call (866) 533-5490.

Members should call (800) 578-0603, then press 1, 7 days a week from 8 a.m. to 8 p.m.

TTY users please call (800) 648-6056. Pharmacy benefits provided by PerformRx, the next generation PBM.

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