



# 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.

<b>For Standard Requests [72 Hours]</b> FAX: (866) 369-6038 Mail: Prior Authorization Department 200 Stevens Drive, Philadelphia, PA 19113	<b>Request for Expedited Review [24 Hours]</b> 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.	<b>HOSPITAL DISCHARGE Request</b> 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:	
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 request 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.