Request for Medicare Prescription Drug Coverage Determination

Who May Make a Request
Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Mail or fax this form:

Address:	Fax Number:
Medicare Coverage Determinations and Appeals MC109 P.O. Box 52000 Phoenix, Arizona 85072-2000	1 (855) 633-7673

You can also ask us for a coverage determination by phone or through our website:
Call 1 (855) 479-3659 seven days a week, 24 hours a day. For TTY, call 711.
Visit hmsa.com/help-center/forms/medicare-drug-review/.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____ Enrollee's Member ID No. _____

Complete the following section only if the person making this request is not the enrollee or prescriber:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for requests made by someone other than the enrollee or the enrollee's prescriber. Attach documents showing the authority to represent the enrollee, such as a completed Authorization of Representation Form CMS-1696 or a written equivalent. For more information on appointing a representative, contact HMSA. You can also call 1 (800) MEDICARE [1 (800) 633-4227] 24 hours a day, seven days a week. TTY: 1 (877) 486-2048

Name of prescription drug you're requesting. If known, include strength and quantity requested per month:

Type of Coverage Determination Request

- ☐ 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 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 prior authorization for the drug my prescriber has prescribed.*
- ☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
- ☐ 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 prescriber prescribed (formulary exception).*
- ☐ My drug plan charges a higher copayment for the drug my prescriber 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).*
- ☐ My drug plan charged me a higher copayment for a drug than it should have.
- ☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

*** If you're asking for a formulary or tiering exception, your prescriber must provide a statement supporting your request. Requests that require prior authorization or any other utilization management requirement may require supporting information. Your prescriber may use the attached Supporting Information for an Exception Request or Prior Authorization to support your request.**

Additional information we should consider (attach any supporting documents):

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we'll automatically give you a decision within 24 hours. If you don't get your prescriber's support for an expedited request, we'll decide if your case requires a fast decision. You cannot request an expedited coverage determination if you're asking us to pay you back for a drug you already received.

☐ **Check this box if you believe you need a decision within 24 hours.** Attach any supporting statement from your prescriber.

Signature	**Date**

Supporting Information for an Exception Request or Prior Authorization

Formulary and tiering exception requests cannot be processed without a prescriber's supporting statement. Prior authorization requests may require supporting information.

☐ **Request for expedited review.** By checking this box and signing below, I certify that applying the 72-hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Prescriber's Signature _____ Date _____

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
Date Started: ☐ New Start	Expected Length of Therapy:	Quantity per 30 days:
Height/Weight:	Drug Allergies:	

Diagnosis. Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes: If the condition being treated with the requested drug is a symptom (such as anorexia, weight loss, shortness of breath, chest pain, or nausea), provide the diagnosis causing the symptom(s) if known:	**ICD-10 Code(s)**
Other relevant diagnoses:	**ICD-10 Code(s)**

Drug History
For treatment of the condition(s) requiring the requested drug.

Drugs tried If quantity limit is an issue, list unit dose/total daily dose tried.	**Dates of drug trials**	**Results of previous drug trials** Failure vs Intolerance (explain)

What's the enrollee's current drug regimen for the condition(s) requiring the requested drug?

Drug Safety

Any FDA noted contraindications to the requested drug? ☐ Yes ☐ No

Any concern for a drug interaction with the addition of the requested drug to the enrollee's current drug regimen? ☐ Yes ☐ No

If the answer to either of the questions above is yes, please explain the issue, discuss the benefits and potential risks despite the noted concern, and discuss a monitoring plan to ensure safety:

High Risk Management of Drugs in Older Adults

If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks? ☐ Yes ☐ No

Opiods
Please complete the following questions if the requested drug is an opioid.

What's the daily cumulative Morphine Equivalent Dose (MED)? _____ mg/day

Are you aware of other opioid prescribers for this enrollee? ☐ Yes ☐ No

If so, please explain:

Is the stated daily MED dose noted medically necessary? ☐ Yes ☐ No

Would a lower total daily MED dose be insufficient to control the enrollee's pain? ☐ Yes ☐ No

Rationale for Request

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome, such as toxicity, allergy, or therapeutic failure. [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change.** A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required. Examples include: The condition has been difficult to control (many drugs tried, multiple drugs required to control condition); or the patient had a significant adverse outcome when the condition was not controlled previously, such as hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, and undue pain and suffering.

☐ **Medical need for different dosage form and/or higher dosage.** Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason; (3) include why less frequent dosing with a higher strength is not an option if a higher strength exists.

☐ **Request for formulary tier exception.** Specify below if not noted in the Drug History section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s); (2) if adverse outcome, list drug(s) and adverse outcome for each; (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed; (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated.

☐ **Other.** Explain below.

Required Explanation:_____

_____

_____

_____

_____

_____