



10680 Treena Street Suite 500
San Diego, CA 92131

Phone: (800) 788-2949
Fax: (858) 790-7100

Medicare Part D Coverage Determination Request Form

This form **cannot** be used to request:

- Medicare non-covered drugs, including 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).

Plan Name:					
Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID#			DEA#		
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:		Directions for use: (Frequency & Strength):			
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:		Expected Length of Therapy: Route of Administration		Qty:	
				Qty per month:	
Height/Weight:		Drug Allergies:		Diagnosis:	
Prescriber's Signature:		MD Specialty		Date:	
Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION					
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure) <ul style="list-style-type: none"> ➤ Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); <input type="checkbox"/> 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 <ul style="list-style-type: none"> ➤ Specify below: Anticipated significant adverse clinical outcome <input type="checkbox"/> Medical need for different dosage form and/or higher dosage <ul style="list-style-type: none"> ➤ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason <input type="checkbox"/> Prior Authorization: Prior Authorization guidelines or Step Requirements Exception Request (ME, FE, QE, CF, CE): <ul style="list-style-type: none"> ➤ 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 <input type="checkbox"/> Medical Exception (ME) – Enrollee would suffer adverse events if subject to the PA requirement <input type="checkbox"/> Formulary Exception (FE) – Medication not on the plan's list of covered drugs <input type="checkbox"/> Quantity Exception (QE) – For a quantity different from the number of doses available under a dose restriction <input type="checkbox"/> Compound Formulary Exception (CF) – Review for a nonformulary compound <input type="checkbox"/> Copay Tier Exception (CE) – Reduction in the member's copay/cost sharing Other: _____ <input type="checkbox"/> Explain below					
REQUIRED EXPLANATION: _____					
Request for Expedited Review					
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] <ul style="list-style-type: none"> ➤ 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					