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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).

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:		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					
<p>Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure)</p> <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); <p>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</p> <ul style="list-style-type: none"> ➤ Specify below: Anticipated significant adverse clinical outcome <p>Medical need for different dosage form and/or higher dosage</p> <ul style="list-style-type: none"> ➤ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason <p>Request for formulary tier exception</p> <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 <p>Other: _____ Explain below</p> <p>REQUIRED EXPLANATION: _____</p> <p>_____</p> <p>_____</p>					
Request for Expedited Review					
<p>REQUEST FOR EXPEDITED REVIEW [24 HOURS]</p> <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 <p>Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA</p>					