

Phone: (800) 788-2949 10680 Treena Street Suite 500 San Diego, CA 92131 (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-

Patient Information Patient Name: Member ID# Address: City: State City: Mem Phone: Sex (circle): Mem Phone: Diagnosis and Medical Information Medication: (Frequency & Strength): (Administration Diagnosis: Prescriber's Signature: MD Specialty MD Specialty MD Specialty MD Specialty Administration 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) adverse outcome for each; (3) if therapeutic failure) Specify below: Anticipated 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) Drug allor significant adverse clinical outcome Medical need for different dosage form significant adverse clinical outcome Specify below: (1) Drug allor significant adverse clinical outcome Specify below: (1) Drug allor significant adverse clinical outcome Specify below: (1) Drug allor significant adverse clinical outcome Specify below: (1) Drug allor significant adverse clinical outcome Specify below: (1) Promulary 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 as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and outcome Medical Exception (FE) — Reduction not on the plan's list of covered drugs Medical Exception (FE) — Reduction in the member's copay/cost sharing Diagraphy and the state: Diagraphy and the state:	Plan Name:							
Member ID# 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: (Frequency & Strength): (Frequency & Strength): (Therapy Initiated: Administration) Medication: (Frequency & Strength): (Therapy Initiated: Administration) Drug Allergies: Diagnosis: Prescriber's Signature: MD Specialty Date: Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION Alternate drug(s) contraindicated or previously fried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure) Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome (i.e., toxicity, allergy, or therapeutic failure, length of therapy on each drug(s); 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 Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason Prior Authorization: Prior Authorization guidelines or Step Requirements Exception Request (ME, FE, QE, CF, CE): Specify below: (1) Thormulary or preferred drugs contraindicated or tried and failed, or tried and not as effective, length of therapy on each drug and outcome Medical Reception (ME) — Enrollee would suffer adverse events if subject to the PA requirement Exception Request (ME, FE, DE, CF, CE): Specify below: (1) Ferned and outcome Medical Exception (ME) — Enrollee would suffer adverse events if subject to the PA requirement Exception (DE) — For a Quantity different from the number of doses available under a dose restriction Compound Formulary Exception (CE) — Reduction in the member's copay/cost sharing Other:	Patient Information			Prescriber Info	rmatio	on		
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): New Prescription OR Date Expected Length of Therapy: Route of Administration Otto Administration Drug Allergies: Diagnosis: Prescriber's Signature: MD Specialty Date: Rationale for Exception Request or Prior Authorization 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) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); 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 Specify below: (1) Dosage form and/or higher dosage Specify below: (1) Dosage form and/or higher dosage Prior Authorization: Prior Authorization guidelines or Step Requirements Exception Request (ME, FE, QE, CF, CE): Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective, length of therapy on each drug and outcome Medical Exception (ME) — Enrollee would suffer adverse events if subject to the PA requirement Formulary Exception (FE) — Medication not on the plan's list of covered drugs Quantity Exception (CE) — For a quantity different from the number of doses available under a dose restriction Compound Formulary Exception (CE) — Review for a nonformulary compound Copay Tier Exception (CE) — Review for a nonformulary compound Other:								
City: State City: State: State	Member ID#			DEA#				
Sex (circle): M F DOB: Contact Person: Diagnosis and Medical Information	Address:			Address:				
Diagnosis and Medical Information	City:		State	City:			State:	
Diagnosis and Medical Information Medication: Directions for use: (Frequency & Strength): Description OR Date Therapy Initiated: Drug Allergies: Drug Allergies: Diagnosis: Prescriber's Signature: MD Specialty Date: Rationale for Exception Request or Prior Authorization 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) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); 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 Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason Medical need for different dosage form and/or higher dosage Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason Prior Authorization: Prior Authorization spidelines or Step Requirements Exception Request (ME, FE, QE, CF, CE): 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 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 Medical Exception (ME) – Enrollee would suffer adverse events if subject to the PA requirement Formulary Exception (FE) – Medication not on the plan's list of covered drugs Quantity Exception (CE) – For a quantity different from the number of doses available under a dose restriction Compound Formulary Exception (CF) – Review for a nonformulary compound Copay Tier Exception (CE) – Reduction in the member's copay/cost sharing	Home Phone:		Zip:	Office Phone# Office Fax:		Office Fax:	Zip:	
Medication: Directions for use:	Sex (circle): M F DOE)B:	Contact Person:				
Medication: Directions for use:			Diagnosis	and Medical Info	rmatic	on		
New Prescription OR Date Expected Length of Therapy: Route of Administration Qty: Qty per month:	Medication:							
Therapy Initiated: Administration								
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 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) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); 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 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; (2) explain medical reason Prior Authorization: Prior Authorization guidelines or Step Requirements Exception Request (ME, FE, QE, CF, CE): 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 Medical Exception (ME) — Enrollee would suffer adverse events if subject to the PA requirement Formulary Exception (FE) — Medication not on the plan's list of covered drugs Quantity Exception (CE) — For a quantity different from the number of doses available under a dose restriction Compound Formulary Exception (CF) — Review for a nonformulary compound Copay Tier Exception (CE) — Reduction in the member's copay/cost sharing Other: Explain below	☐ New Prescription OR Date E				ute of	Qty:	Qty:	
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Other: Explain below	□ Alternate drug(s) contraindicat ➤ Specify below: (1) Dru therapy on each drug(s) □ Complex patient with one or m current drug(s); high risk of signi ➤ Specify below: Anticip □ Medical need for different dos ➤ Specify below: (1) Dos □ Prior Authorization: Prior Auth Exception Request (ME, FE, QE ➤ Specify below: (1) For requested drug; (2) if th length of therapy on ea □ Medical Exception (ME) - En □ Formulary Exception (FE) - N □ Quantity Exception (QE) - Fo	ted or g(s) co g(s) co); nore ch ficant a ated si age fo orization , CF, C mulary erape ch dru- rollee Medica r a qua ion (C	previously tried, be contraindicated or contraindicated or contraindicated or contraindicated or contraindicated or contraindicated or contraindicant adverse comments of contraindicated or contraindicate	out with adverse outcutried; (2) adverse outcutried; (2) adverse outcutried; (2) adverse outcutried; (2) adverse outcome with medicate clinical outcome dosage age(s) tried; (2) explained by the contraindicated or not therapy on each of the covered draws its of covered draws the number of dos	ome (i.e. come for come for characteristics and come for characteristics and come for come fo	e., toxicity, allergy or each; (3) if the chiatric condition, nge dical reason and failed, or tried d adverse outcor	y, or therapeutic failure) rapeutic failure, length of diabetes) is stable on and not as effective as me; (3) if not as effective,	
REQUIRED EXPLANATION:		RACITIC						
	□ Copay Tier Exception (CE) -		ction in the memb	er's copay/cost shari	ng 	□ E	Explain below	

□ REQUEST FOR EXPEDITED REVIEW [24 HOURS]

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

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