Plan Name	
Phone #	
Fax #	

## 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).

> Biotech or other specialty drugs for which drug-specific forms are required. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04 Formulary.asp]

[See links to plan websites at h	ttp://www.	cms.hhs.gov/Pre	escriptionDrugCovGenl	n/04_Form	ulary.asp]			
Patient Infor	Prescriber Information							
Patient Name:	Prescriber Name:							
Member ID#:	NPI# (if available):							
Address:	Address:							
City:	State:	City: State			State:			
Home Phone:	Zip:	Office Phone #:	Office Fax #: Zip:					
Sex (circle): M F DOB:			Contact Person:					
	Diag		edical Information		_			
Medication:	Strength and	ength and Route of Administration:			Frequency:			
☐ New Prescription OR Date Therapy Initiated:	Expected Len	ed Length of Therapy:			Qty:			
Height/Weight: Drug Allergies: Diagnosis:					<u> </u>			
			T D (					
Prescriber's Signature:		Date:						
D-41-	l. fa F		A Dui A41-					
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 (eg, toxicity, allergy, or therapeutic failure)								
→ Specify below: (1) Drug( length of therapy on each dr		dicated or tried;	(2) adverse outcome	for each; (	3) if therape	eutic failure,		
☐ 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								
☐ Request for formulary tier ex		<b>5</b> (	, , , , ,					
→ Specify below: (1) Form effective as requested dr (3) if not as effective, lend	iulary or pr ug; (2) if t	herapeutic failu	re, length of therapy or					
Other:						→ Explain below		
REQUIRED EXPLANATION:								
						<del></del>		
			and the LD and are					

## Request for Expedited Review

☐ 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.