REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION							
This form may be sent to us by mail or fax:							
10181 Scripps (-ateway Court	Fax Number: Phone Number: 1-800-788-2949						
You may also ask us for a coverage determination by phone at 1-800-788-2949 or through our website at https://mp.medimpact.com/partdcoveragedetermination.							
Who May Make a Request: Your prescribehalf. If you want another individual (sucyou, that individual must be your represe	ch as a family membe	er or friend) to make a request for					
Enrollee's Information		Data (Did					
Enrollee's Name		Date of Birth					
Enrollee's Address							
City	State	Zip Code					
Phone	Enrollee's Member ID #						
Complete the following section ONLY if the person making this request is not the enrollee or prescriber:  Requestor's Name							
or prescriber: Requestor's Name							
or prescriber:		g roquost is not s					
or prescriber: Requestor's Name		g roquost is not c					
or prescriber:  Requestor's Name  Requestor's Relationship to Enrollee	State	Zip Code					
or prescriber:  Requestor's Name  Requestor's Relationship to Enrollee  Address							
or prescriber:  Requestor's Name  Requestor's Relationship to Enrollee  Address  City  Phone	State	Zip Code					
or prescriber:  Requestor's Name  Requestor's Relationship to Enrollee  Address  City  Phone  Representation documentation for re	State	Zip Code					
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Type of Coverage Determination Requ	iest			
$\hfill\square$ I need a drug that is not on the plan's list of covered drugs (formula $\hfill$	lary exception).*			
$\hfill\Box$ I have been using a drug that was previously included on the plan being removed or was removed from this list during the plan year (for				
$\hfill\square$ I request prior authorization for the drug my prescriber has prescri	ribed.*			
$\Box$ I request an exception to the requirement that I try another drug by prescriber prescribed (formulary exception).*	efore I get the drug my			
$\Box$ I request an exception to the plan's limit on the number of pills (quantum that I can get the number of pills my prescriber prescribed (formulary	• •			
$\Box$ My drug plan charges a higher copayment for the drug my prescr for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*	•			
$\hfill\square$ I have been using a drug that was previously included on a lower moved to or was moved to a higher copayment tier (tiering exception				
$\hfill\square$ My drug plan charged me a higher copayment for a drug than it s	hould have.			
$\Box I$ want to be reimbursed for a covered prescription drug that I paid	for out of pocket.			
a statement supporting your request. Requests that are subject any other utilization management requirement), may require supprescriber may use the attached "Supporting Information for an Authorization" to support your request.	pporting information. Your			
Additional information we should consider (attach any supporting do	cuments):			
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 will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.				
☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION \				
have a supporting statement from your prescriber, attach it to this request).				
Signature:	Date:			
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## Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXC supporting statement. PRIOR AL						
REQUEST FOR EXPEDITED hat applying the 72 hour stand lealth of the enrollee or the enrollee in the enrollee or the enrollee.	ard review time	frame m	ay seriously jeop	oardiz		
Name						
Address						
City	State		Zip Code			
Office Phone		Fax	I			
Prescriber's Signature			Date			
Medication:	Strength and	Route of	of Administration: Freque		uency:	
Date Started: □ NEW START	Expected Len	Expected Length of Therapy: Quai		ntity per 30 day		
Height/Weight:	Drug Allergie	S:				
DIAGNOSIS – Please list all diagram and corresponding ICD-1 (If the condition being treated with the requirement, chest pain, nausea, etc., provide the	<b>0 codes.</b> ested drug is a sympto	m e.g. anor	exia, weight loss, shorti		ICD-10 Code(s)	
Other RELAVENT DIAGNOSES	3:				ICD-10 Code(s)	
DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	DATES of Dru	g Trials	RESULTS of pr FAILURE vs IN		_	
What is the enrollee's current dru	g regimen for the	conditio	n(s) requiring the	reques	sted drug?	

DRUG SAFETY						
Any FDA NOTED CONTRAINDICATIONS to the requested drug?	☐ YES					
Any concern for a DRUG INTERACTION with the addition of the requested drug to the	e enrollee's c	urrent				
drug regimen?	□ YES	□ NO				
If the answer to either of the questions noted above is yes, please 1) explain issue, 2) vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety	discuss the b	penefits				
HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY						
If the enrollee is over the age of 65, do you feel that the benefits of treatment with the	requested dru	ug				
outweigh the potential risks in this elderly patient?	□ YES					
OPIOIDS – (please complete the following questions if the requested drug is an opioi						
What is the daily cumulative Morphine Equivalent Dose (MED)?		mg/day				
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	□ YES	□ NO				
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					
RATIONALE FOR REQUEST						
□ Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. 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 – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.						
☐ <b>Medical need for different dosage form and/or higher dosage</b> [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						