

<p style="text-align: center;">Model Form Instructions Request for a Medicare Prescription Drug Coverage Determination</p>

Purpose of Model Form

This model form was developed in response to requests from outside parties to provide guidance to enrollees on requesting coverage determinations (including exception requests) from Part D plans. It is intended to provide basic information to enrollees on how to ask for a coverage determination from a Medicare drug plan.

Under the Medicare Part D prescription drug benefit program, a Part D plan enrollee can request a coverage determination, including a request for a tiering or formulary exception. A request can also be made on behalf of the enrollee by the enrollee's appointed representative or the enrollee's prescribing physician. A request for a standard coverage determination is generally made in writing, but a plan can choose to accept oral requests. A request for an expedited coverage determination can be made orally or in writing. An enrollee, the enrollee's appointed representative, or the enrollee's prescribing physician may submit a written request for a coverage determination in any format.

Use of Model Form

Use of this model form is **optional**. The **format and content of this model form may be changed** by any person or entity (e.g., enrollee, Part D plan) that uses it. Enrollees, appointed representatives, and prescribing physicians who wish to use this form should contact the enrollee's Medicare drug plan to find out if the plan uses a different form. **If this model form is used, the Medicare drug plan may require additional information or documentation to support the enrollee's request.** A plan that chooses to use this model form should modify the form, as necessary, to include information on relevant plan policies and procedures.

<p style="text-align: center;">Use of this model form is optional and its content may be changed.</p>

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations)

Enrollee's/Requestor's Information

Enrollee's Name

Enrollee's Date of Birth

Enrollee's Medicare Number

Enrollee's Part D Plan ID Number

Requestor's Name (if not enrollee)

Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

Enrollee/Requestor's Address

City

State

Zip Code

()

Phone

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

Prescribing Physician's Information

Name

Medical Specialty

Address

City

State

Zip Code

()

Work Phone

()

Fax

Office Contact Person

Type of Coverage Determination Request

I need a drug that is not on the plan's list of covered drugs (formulary exception). *

I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception). *

- I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*
- I request prior authorization for the drug my doctor has prescribed.
- I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*
- My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.**

Additional information we should consider (*attach any supporting documents*):

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

- I need an expedited coverage determination (attach physician's supporting statement, if applicable)

Beneficiary/Requestor's Signature

Date

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.