

**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). \*

