Print Clear form

MASSACHUSETTS

MEDICARE PART D COVERAGE DETERMINATION REQUEST FORM

Please fax this completed form to Clinical Pharmacy at **1-866-463-7700**.
Questions? Call **1-800-366-7778**.

MEMBER INFORMATION

Member name:	
Member ID:	
Address:	
Phone #:	
Date of birth:	

PRESCRIBER INFORMATION

Prescriber name:	
NPI:	
Address:	
Phone #:	
Fax #:	

DIAGNOSIS AND MEDICAL INFORMATION

Medication (name and strength):		Quantity requested:	
Route of administration:		Directions for use:	
Expected length of therapy:		New prescription OR date therapy initiated:	
Member's diagnosis or ICD-10 code:			
Prescriber's signature:		Date:	

❑ 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.

TYPE OF COVERAGE DETERMINATION REQUESTED (SELECT ALL THAT APPLY)

❑	**Exception Request** (Formulary Exception request for non-formulary drug, Quality Care Dosing override for drug with quality care dosing limit)
❑	**Prior Authorization Request or Step Therapy Requirement**
❑	**Exception to Prior Authorization Request or Step Therapy Requirement (**requesting individual consideration for member who does not meet Medical Policy criteria and requires coverage outside Medical Policy guidelines)
❑	**Tiering Exception Request** (*Note: not all medications are eligible for tiering exception)

PREVIOUS THERAPIES

Drug name	Strength	Dosing schedule	Date prescribed	Date stopped	Description of adverse reaction or failure	Check if sample
						❑
						❑
						❑
						❑
						❑

Are there contraindications to alternative therapies? ❑ Yes ❑ No If yes, please list details below:

RELEVANT LAB VALUES

Lab name and lab value	Date performed	Lab name and lab value	Date performed

If renewal, has the patient shown improvement in related condition while in therapy? ❑ Yes ❑ No ❑ N/A
If yes, please describe:

ADDITIONAL INFORMATION PERTINENT TO THIS REQUEST