

## **Instructions for completing the Request for Medicare Prescription Drug Coverage Determination Form**

This form can be used by Part D enrollees requesting coverage determinations (including tiering or formulary exception requests) from their Part D plan. It is intended to provide basic information to enrollees on how to ask for a coverage determination from a Medicare drug plan.

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.

Please take this form to your physician for completion. In addition, have your physician visit the website [www.WellpointNextRx.com](http://www.WellpointNextRx.com) and select "Physician PAB forms" to locate your Medicare Part D plan and the drug specific **Prior Authorization of Benefit form**.

These two forms should be forwarded to the fax number found on the Prior Authorization of Benefits Form.

**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 Address

City

State

Zip

( )

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

( )

Work Phone

( )

Fax

Office Contact Person

Enrollee Name \_\_\_\_\_

Enrollee Part D Plan ID Number \_\_\_\_\_

**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).\*

**\*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's/Requestor's Signature

\_\_\_\_\_  
Date

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