REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:
CVS Caremark - Appeals Department
MC 109
PO Box 52000
Phoenix, AZ 85072-2000

Fax Number:
1-855-633-7673

You may also ask us for a coverage determination by phone at 1-855-675-7630, TTY/TDD 711, or through our website at www.healthfirst.org/mmp.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

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		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare (1-800-633-4227).

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

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 prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ 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 prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber 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).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐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 prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

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

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Important Note: Expedited Decisions

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 WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature:	**Date:**

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐**REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature	Date	

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:
Rationale for Request		

☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]

☐ **Request for formulary tier exception** [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]

☐ **Other** (explain below)
Required Explanation ____

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Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan) is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

Participants generally must use network pharmacies to access their prescription drug benefit.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

You can get this information for free in other languages. Call 1-855-675-7630 and TTY/TDD 711, 7 days a week from 8 am to 8 pm. The call is free.

Usted puede obtener esta información de forma gratuita en otros idiomas. Llame al 1-855-675-7630 y al TTY/TDD 711, los 7 días de la semana de 8:00 a.m. a 8:00 p.m. La llamada es gratuita.

Вы можете получить эту информацию бесплатно на других языках. Звоните по телефону 1-855-675-7630 или 711 (для пользующихся TTY/TDD) 7 дней в неделю с 8 утра до 8 вечера. Звонок бесплатный.

本資訊有其他語言版本供免費索取。請致電1-855-675-7630，聽力語言殘障服務專線TTY/TDD 711，服務時間每週七天，每天上午8時至晚上8時。以上均為免費電話。

이와 동일한 정보를 무상으로 다른 언어 버전으로도 얻으실 수 있습니다. 문의는 1-855-675-7630(TTY/TDD 711)으로 연중무휴 오전 8시에서 오후 8시 사이에 연락 주십시오. 통화는 무료입니다.

Ou kapab jwenn enfòmasyon sa yo gratis nan lòt lang yo. Rele nimewo 1-855-675-7630 ak TTY/TDD 711 pandan 7 jou pa semèn depi 8 am jiska to 8 pm. Koutfil la gratis.

È possibile ottenere queste informazioni gratuitamente in altre lingue chiamando il numero 1-855-675-7630 (utenti TTY/TDD: 711), 7 giorni alla settimana dalle 8 alle 20. La telefonata è gratuita.

You can ask for this notice in other formats, such as Braille or large print. Call 1-855-675-7630 or TTY: 711, 7 days a week from 8 am to 8 pm.

Healthfirst Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan). The Participant Ombudsman may be reached toll-free at 1-844-614-8800, TTY 711 or online at icannys.org.