## REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

Address: Fax Number: 504-849-6901
Peoples Health
Three Lakeway Center 3838 N. Causeway Blvd., Ste. 2200
Metairie, LA 70002

You may also ask us for a coverage determination by phone toll-free at 1-800-222-8600 or through our website at http://www.peopleshealth.com/coveragedecision.

<u>Who May Make a Request</u>: 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:

or presenter.		
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.

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.		
a stat any o preso	E: If you are asking for a formulary or tiering exception, your prescriber MUST provide tement supporting your request. Requests that are subject to prior authorization (or other utilization management requirement), may require supporting information. Your criber may use the attached "Supporting Information for an Exception Request or Prior orization" to support your request.		
Additi	ional information we should consider (attach any supporting documents):		

Important Note: Expedited Decisions					
f you or your prescriber believe that your life, health, or ability to regain refuser prescriber indicates that wait automatically give you a decision when expedited request, we will decide expedited coverage determination in received.	maximing 72 ithin 2 ithin you	ium function hours co hours. If ur case re	on, you can ask uld seriously ha f you do not obt quires a fast de	k for an exp arm your h tain your p ecision. Yo	pedited (fast) decision. ealth, we will rescriber's support for u cannot request an
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	n for	an Excep	tion Request	or Prior A	uthorization
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 time frame 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	City State .		Zip Code		
Office Phone			Fax		
Prescriber's Signature				Date	
<b>Diagnosis and Medical Informati</b>	ion				
Medication:	Strength and Route of Administration: Frequency:		Frequency:		
Date Started:  ☐ NEW START	Expected Length of Therapy: Quantity per 30 days				
Height/Weight:	Dru	g Allergies	S:		

DIAGNOSIS - Please list all diagn	ICD-10 Code(s)			
drug and corresponding ICD-10 co				
(If the condition being treated with th				
anorexia, weight loss, shortness of b		, etc., provide the		
diagnosis causing the symptom(s) if	known)			
Other RELEVANT DIAGNOSES:			ICD-10 Code(s)	
Guior Releviati Birtortoces.			100 10 0000(0)	
<b>DRUG HISTORY:</b> (for treatment of t	he condition(s) requiring t	he requested drug)		
DRUGS TRIED	DATES of Drug Trials	RESULTS of prev	ious drug trials	
(if quantity limit is an issue, list unit		FAILURE vs INTO	_	
dose/total daily dose tried)		(explain)		
, , , , , , , , , , , , , , , , , , , ,		,		
What is the enrollee's current drug re	egimen for the condition(s	s) requiring the requ	ested drug?	
DRUG SAFETY				
Any FDA NOTED CONTRAINDICAT	<b>FIONS</b> to the requested d	rug?	☐ YES ☐ NO	
Any concern for a DRUG INTERACT	<b>FION</b> with the addition of t	he requested drug t	to the enrollee's	
current drug regimen?		,	$\square$ YES $\square$ NO	
If the answer to either of the question	ns noted above is yes, ple	ease 1) explain issue	e, 2) discuss the	
benefits vs potential risks despite the noted concern, and 3) discuss a monitoring plan to ensure				
safety				
-				
HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY				
If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested				
drug outweigh the potential risks in t	☐ YES ☐ NO			
arag catholy in the potential hold in t	ino ordony patient:		110	

OPIOIDS - (please complete the following questions if the requested drug is	an opioid)
What is the daily cumulative Morphine Equivalent Dose (MED)?	mg/day
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	□ YES □ NO
Is the stated daily MED dose noted medically necessary?	
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	☐ YES ☐ NO
RATIONALE FOR REQUEST	toomo o d
□ Alternate drug(s) contraindicated or previously tried, but with adverse out toxicity, allergy, or therapeutic failure Specify below if not already noted in the HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specifierred drug(s)/other formulary drug(s) are contraindicated	e DRUG b), (2) if adverse t maximum dose
□ Patient is stable on current drug(s); high risk of significant adverse clinical medication change A specific explanation of any anticipated significant adverse outcome and why a significant adverse outcome would be expected is required condition has been difficult to control (many drugs tried, multiple drugs required condition), the patient had a significant adverse outcome when the condition was previously (e.g., hospitalization or frequent acute medical visits, heart attack, straignificant limitation of functional status, undue pain and suffering), etc.	e clinical  – e.g., the to control s not controlled
☐ <b>Medical need for different dosage form and/or higher dosage</b> Specify below form(s) and/or dosage(s) tried and outcome of drug trial(s), (2) explain medical include why less frequent dosing with a higher strength is not an option – if a higher strength is not an option – if a higher strength is not an option if a higher strength is not an option – if a higher s	reason, (3)
□ Request for formulary tier exception Specify below if not noted in the DRUG section earlier on the form: (1) formulary or preferred drug(s) tried and results of (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therape as effective as requested drug, list maximum dose and length of therapy for drug contraindication(s), please list specific reason why preferred drug(s)/other formulation contraindicated	f drug trial(s), eutic failure/not g(s) trialed, (4) if
☐ <b>Other</b> (explain below)	
Required Explanation	