



## Request for Medicare Prescription Drug Coverage Determination

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

**Address**

**Fax Number**

Highmark Wholecare Medicare Assured<sup>SM</sup>  
Four Gateway Center  
444 Liberty Avenue, Suite 2100  
Pittsburgh, PA 15222-1222

1-888-447-4369

You may also ask us for a coverage determination by phone:

1-800-685-5290

TTY users should call 71

**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.

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):

---

---

---

**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 of person requesting the coverage determination (the enrollee, or the enrollee’s prescriber or representative):**

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 \_\_\_\_\_  
 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Highmark Wholecare offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Highmark Wholecare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-685-5209 (TTY 711).

ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-800-685-5209 (TTY 711).

小小贴士：如果您说普通话，欢迎使用免费语言协助服务。请拨 1-800-685-5209 (TTY 711)。

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).