Scan and Email to: PartDServices@HealthSun.com
Telephone: (305) 460-3901
Fax: (305) 643-4323

Medicare Prescription Drug Coverage Determination Request Form

Intended for Prescriber use

Member Information			Prescriber Information		
Member Name:			Prescriber's Name: Dr.		
Member ID#:			NPI# (if available):		
Address:			Address:		
City:		State: FL	City:		State: FL
Home Phone:		Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle): M F	DOB:				

Diagnosis and Medical Information

Medication:	Strength and Route of Administration:	Frequency:
New Prescription or Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:

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.

Rationale for Request:

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure

(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

Anticipated significant adverse clinical outcome:____________________

☐ Medical need for different dosage form and/or higher dosage

(1) Dosage form(s) and/or dosage(s) tried:____________________

(2) explain medical reason:____________________

☐ Request for formulary tier/step therapy exception

(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:____________________

____

____

☐ **REQUEST FOR EXPEDITED REVIEW [DECISION WITHIN 24 HOURS]:** 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 member or the member's ability to regain maximum function.

Prescriber's Signature:	Today's Date:

REVIEWED 12/13/2016

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