



Coverage Determination Form
 Formulary: www.Meds4Medicare.com
 Forms: Fax on Demand 1.866.772.7737
FAX TO: 1.866.855.2676

This form cannot be used to request drugs excluded from Medicare Part D, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, cough and cold, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

•• Only one medication request per form •• All fields must be complete and legible for review ••

<input type="checkbox"/> STANDARD REVIEW [72 HOURS]		<input type="checkbox"/> EXPEDITED REVIEW [24 HOURS]	
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain optimal function.			
PATIENT/PREScriBER INFORMATION		MEDICATION INFORMATION	
Patient Name:		Medication, Strength and Route of Administration:	
Member ID#:		Diagnosis/ICD 9:	
Date of Birth:	Patient Phone Number:	Expected Length of Therapy:	<input type="checkbox"/> New Prescription -OR- Date Therapy initiated: / /
Patient Height/Weight/BMI:		Drug Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No (Please List)	
Physician Name:		If injectable, is patient self-administering drug? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who will administer drug:	
Physician DEA or NPI:	Contact Person:	If Transplant Drug: Was the transplant covered by Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date:	
Office Phone:	Office Fax:	Pharmacy Name, Phone and Fax:	
RATIONALE FOR EXCEPTION REQUEST OR PRIOR AUTHORIZATION			
<input type="checkbox"/> 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);			
<input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change Specify below: Anticipated significant adverse clinical outcome			
<input type="checkbox"/> Medical need for different dosage form &/or higher dosage Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason			
<input type="checkbox"/> Request for formulary tier exception List alternate drug(s) contraindicated or previously tried, but with adverse outcome(s) (e.g. toxicity, allergy, or therapeutic failure): (1) Drug(s) tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); (1) _____ (2) _____ (3) _____ (1) _____ (2) _____ (3) _____ (1) _____ (2) _____ (3) _____			
In order to complete the review process, chart notes documenting trial and failure on the above medication and pertinent laboratory tests and results must be included			
Prescriber's Signature:			Date:

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.