



AmeriHealth Rx
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Medicare Part D Coverage Determination Request Form

This form is cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- **Biotech or other specialty drugs for which drug-specific forms are required. [See www.amerihealth65.com.]**

Patient Information				Prescriber Information			
Patient Name:				Prescriber Name:			
Member ID#:				NPI# (if available):			
Address:				Address:			
City:		State:		City:		State:	
Home Phone:		Zip:		Office Phone #:		Office Fax #:	Zip:
Sex (circle): M F		DOB:		Contact Person:			

Diagnosis and Medical Information						
Medication:		Strength and Route of Administration:			Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:			Qty:	
Height/Weight:	Drug Allergies:		Diagnosis:			
Prescriber's Signature:					Date:	

Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, 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);
- 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 adverse 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, 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

EXPLANATION REQUIRED: _____

Request for Expedited Review
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] ➔ BY CHECKING THIS BOX AND SIGNING ABOVE, 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 MAXIMUM FUNCTION