



Phone #: 1-866-369-6037

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## Medicare Part D Coverage Determination Request Form

This form 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.amerithealthpdp.com](http://www.amerithealthpdp.com) OR See links to plan websites at [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04\\_Formulary.asp](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp).**

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 (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)
- 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
- 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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.**