

Plan Name: Community Care

Phone #: (866) 992-6600

Fax #: (414) 274-8490

## 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 <http://www.communitycareinc.org/Assets/Formulary.pdf> -OR-
- See <http://www.medicare.gov/MPDPF/Shared/Include/Formulary/FormularyFinder.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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Contact Person:		
Diagnosis and Medical Information				
Medication:	Strength & 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				
<input type="checkbox"/> 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);				
<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 and/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 → 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				
<input type="checkbox"/> Other: _____ → Explain below				
<b>REQUIRED EXPLANATION:</b> _____				
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.