REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:
CVS/Caremark
P.O. Box 52000
MC109
Phoenix, AZ 85072-2000

Fax Number: 1-855-633-7673

You may also ask us for a coverage determination by phone at 866-443-0935 or 711 for TTY or through our website at www.elderplanfida.org.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name ____ Date of Birth ________________

Enrollee's Address ____

City ______________________________ State________________ Zip Code ________________

Phone ______________________________ Enrollee's Member ID # ______________________________

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name ____

Requestor's Relationship to Enrollee ____

Address ____

City ______________________________________ State _________ Zip Code _______________

Phone ________________________________

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider *(attach any supporting documents)*:

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Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature of person requesting the coverage determination (the enrollee, or the enrollee's prescriber or representative):

____ **Date:** ______________

Supporting Information for an Exception Request or Prior Authorization

FORMULARY EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ **REQUEST FOR EXPEDITED REVIEW: 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 enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information

Name ____

Address ____

City ____________________________ State ________ Zip Code ________________

Office Phone____________________________ Fax ______________________________

Prescriber's Signature ________________________________ **Date**________________

Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

Rationale for Request

☐ **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)]

☐ **Patient 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]

☐ **Other** (explain below)

Required Explanation:____

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

Elderplan FIDA Total Care is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Participant Handbook.

Limitations and restrictions may apply. For more information, call Elderplan FIDA Total Care Participant

Services or read the Elderplan FIDA Total Care Participant Handbook. This means that you need to follow certain rules to have Elderplan FIDA Total Care pay for your services.

Benefits, List of Covered Drugs, and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year.

You can get this information for free in other languages. Call 1-855-462-3167 and TTY users call 711 during 8am to 8pm seven days a week. The call is free.

Puede obtener esta información de manera gratuita en otros idiomas. Llame al 1-855-462-3167 y TTY/TDD 7-1-1 de lunes a domingos de 8:00 am a 8:00 pm. La llamada es gratuita.

Ou ka jwenn enfòmasyon sa a gratis nan lòt lang. Rele nan 1-855-462-3167 ak nan TTY/TDD (pou moun ki gen pwoblèm tande oswa moun ki bèbè) 7-1-1 de lendi a dimanch 8:00 am - 8:00 pm. Apèl la gratis.

이정보는다른언어로도제공됩니다(무료). 월요일-일요일8:00 am – 8:00 pm 중1-855-462-3167 나 TTY/TDD 7-1-1 로전화주십시오. 통화료는무료입니다.

您可免費取得以其他語言撰寫的資訊。請於週一至週日上午8 時至下午8時致電 1-855-462-3167, TTY/TDD 使用者：7-1-1。此為免付費電話。

Данная информация доступна бесплатно на других языках. Звоните по номеру 1-855-462-3167 или 7-1-1 (линия TTY/TDD) с понедельника по воскресенье с 8:00 до 20:00. Звонок бесплатный.

È possibile riceverequeste informazioni in altre lingue gratuitamente. Contatta il 855-462-3167 eTTY/TDD 7-1-1 dal lunedì alla domenica dalle ore 8:00 alle ore 20:00. Il servizio è gratuito.

You can ask for this handbook in other formats such as large print. Call 1-855-462-3167, 8 a.m. to 8 p.m., 7 days a week (TTY users should call 711).

The State of New York has created a Participant Ombudsman Program to provide Participants free, confidential assistance on any services offered by Elderplan FIDA Total Care. The Participant Ombudsman may be reached toll-free at 1-844-614-8800 or online at www.icannys.org.