

Enrollee/Requester's Address City State Zip Code

() Phone

Name of prescription drug you are requesting: (Please try and spell the name of the medication accurately. If known, include strength, quantity and quantity requested per month):

Prescribing Physician's Information: (Please give us the name of the doctor who wrote your prescription and specialty. Fill out as much of the rest of the information that you know.)

Name

Medical Specialty

Address City State Zip Code

() _____ () _____

Work Phone

Fax

Office Contact Person

Type of Coverage Determination Request: Please check the box that most accurately describes your request. You may check more than one box. If you are asking for a formulary or tiering exception, your prescribing physician must provide documentation such as progress notes or lab results from your chart to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier (Tier 4). In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.

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

I request prior authorization for the drug my doctor has prescribed.

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 doctor prescribed (formulary exception).*

My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering 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 or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering**

exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.

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

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

[] I need an expedited coverage determination (attach physician's supporting statement, if applicable)

Beneficiary/Requester's Signature

Date