



## REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

Under the Medicare Part D prescription drug benefit program, a Part D plan enrollee can request a coverage determination, including a request for a tiering or formulary exception. A request can also be made on behalf of the enrollee by the enrollee's appointed representative or the enrollee's prescribing physician. A request for a standard coverage determination is to be made in writing by filling out the Drug Coverage Determination Form. A request for an expedited coverage determination can be made orally or in writing. Once you have completed the form, please mail it along with any supporting documentation to:

VISTA  
Pharmacy Department  
1340 Concord Terrace  
Sunrise, FL 33323

Or if you prefer, fax the completed form to: 954-858-3386.

For any further questions or if you want to determine the status of your request, please contact VISTA, 7 days per week from 8:00AM – 8:00PM at the numbers listed below:

VISTA Healthplan Members 1-800-977-7339  
VISTA South Florida Members 1-800-842-7442  
TDD 1-888-444-7352 for speech and hearing impaired

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

**Enrollee's/Requester's Information:** (This section must be filled out completely. If you are not the enrollee, please give your contact information as requested.)

\_\_\_\_\_  
Enrollee's Name

\_\_\_\_\_  
Enrollee's Date of Birth

\_\_\_\_\_  
Enrollee's Medicare Number

\_\_\_\_\_  
Enrollee's Part D Plan ID Number

\_\_\_\_\_  
Requester's Name (if not enrollee)

\_\_\_\_\_  
Requester's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

\_\_\_\_\_

Enrollee/Requester's Address City State Zip Code

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( ) 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**

