

*****Only complete forms can be processed. Incomplete forms may result in an administrative denial due to lack of information***
For Tufts Medicare Preferred PDP members, [click here](#) for criteria/request form for Medicare Part B vs Part D Coverage Determinations.**

Fax/mail completed forms to: Tufts Health Plan Precertification Department, 705 Mount Auburn Street, Watertown, MA 02472 - Fax: (617) 972-9409

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ Member THP ID: _____

Diagnosis: _____

Relevant Co-morbid Diagnoses: _____

Additional Comments: _____

PRESCRIBER INFORMATION

Name: _____ Specialty: _____

Provider ID: _____ Tufts Health Plan Provider ID: _____

Phone: _____

Fax: _____ Office Contact: _____

Prescriber Signature (required): _____

REQUESTED DRUG INFORMATION

Type of Program Override Request (check one):

Quantity Limitation Non-covered Drug Step Therapy Prior Authorization

Drug Name/Strength/Dosage Form: _____

Duration of requested treatment: _____

Reason for Coverage Request (check one):

_____ Treatment failure (drug(s)): _____

_____ Adverse reaction (drug(s)): _____

_____ Other clinical reason(s): _____

Duration of treatment with failed drug(s): _____

Antifungals (itraconazole (Sporanox), Penlac, terbinafine (Lamisil), etc.)

Does the patient have uncomplicated onychomycosis? ___ Yes* ___ No

1. Limited to nail surface? ___ Yes ___ No
2. Lunular involvement? ___ Yes ___ No
3. Does the patient have a medical contraindication to oral antifungal therapy
(Penlac only): ___ Yes (explain) _____ No ___
4. Check all that apply:
 Paronychia Diabetes Mellitus
 Systemic Fungus Immune Suppression
 Peripheral Vascular Disease None
 Medically significant pain (Office notes required)

* Any request for coverage with a diagnosis of uncomplicated onychomycosis will be denied as a benefit exclusion.

Drug List and Clinical Criteria available online at tuftshealthplan.com

This section applies for Tufts Health Plan Medicare Preferred ONLY

Expedited Review** _____

** Only check this box if standard review time frame may seriously jeopardize the life or health of the member or member ability to regain maximum function

Aranesp, Epogen, Procrit

Is this being used to treat anemia in a patient with chronic renal failure that undergoes dialysis ___ Yes ___ No

Tier exception request: ___ Yes ___ No

Please specify reason(s) for request:

- _____ Formulary/Preferred drug(s) contraindicated or tried and failed, or not as effective as requested drug
- _____ Therapeutic failure or not as effective; please indicated length of therapy of each applicable drug and adverse outcome
- _____ Other; please explain below

Explanation: _____