TUFTS Health Plan
Medicare Preferred

Request For Medicare Prescription Drug Coverage Determination

This form may be sent to us by mail or fax:	
Address: Pharmacy Utilization Management Department Tufts Health Plan Medicare Preferred 705 Mt. Auburn Street Watertown, MA 02472	**Fax Number:** 1-617-673-0956
You may also ask for a coverage determination by phone at 1-800-701-9000 (TTY 1-800-208-9562) or through our website at **tuftsmedicarepreferred.org**. Monday - Friday, 8:00 a.m. - 8:00 p.m. (Representatives are available 7days a week, 8:00 a.m - 8:00 p.m. from Oct. 1 - Feb. 14.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.	

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:		Enrollee's Date of Birth:
Enrollee's Medicare Number:	Enrollee's Plan ID Number:	
Requestor's Name (if not the enrollee or prescriber):		
Representation documentation for requests made by someone other than the enrollee or the enrolee'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 us or 1-800-Medicare.		
Enrollee's / Requestor's Address:		
City:	State: Zip:	Phone: ( )
Prescription Drug You Are Requesting		
Name of Drug:	Strength / Quantity / Dose:	
Have you purchased the drug pending coverage determination? ☐ Yes ☐ No		
If "Yes" Date Purchased:	Amount Paid (attach receipt):	
Name and telephone number of pharmacy:		
Prescriber's Information		
Name:		
Address:	City:	State: Zip:
Office Phone: ( )	Fax: ( )	

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 physician has prescribed.*

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

☐ My drug plan charges a higher copayment for the drug my prescriber 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).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ 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 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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_____

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Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision coul d seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician 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).**

Member / Requestor / Prescriber Signature:	**Date:**

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING 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.**

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

☐ 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

☐ Other:_____ (explain below)

REQUIRED EXPLANATION: _____

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Prescriber's Signature:	**Date:**

Tufts Health Plan Medicare Preferred is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan Medicare Preferred depends on contract renewal.

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