

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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 Name

Enrollee's Date of Birth

Enrollee's Medicare Number

Enrollee's Part D Plan ID Number

Requestor's Name (if not enrollee)

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

Enrollee/Requestor's Address

City

State

Zip Code

()
Phone

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

Prescribing Physician's Information

Name

Medical Specialty

Address

City

State

Zip Code

()
Work Phone

()
Fax

Office Contact Person

TYPE OF COVERAGE DETERMINATION REQUEST

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

***NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request.**

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/Requestor's Signature

Date

Send this request to your Medicare drug plan (see below). Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.

Scott & White Health Plan
Prescription Services
2601 Thornton Lane, Suite A
Temple, TX 76502
Fax: 254-742-3109
Phone: 800-728-7947