10181 Scripps Gateway Court
San Diego, CA 92131

PHP PARTNERS HEALTH PLAN

MedImpact

Fax: (858) 790-7100

Medicare Part D Coverage Determination Request Form

This form is being used for:

Check one: ☐ Initial Request ☐ Continuation of Therapy/Renewal Request

Reason for request *(check all that apply)*: ☐ Prior Authorization ☐ Formulary Exception ☐ Quantity Exception
☐ Compound Formulary Exception ☐ Copay Tier Exception ☐ Other *(please specify)*: _____

Patient Information

Patient Name:	DOB:		
Drug Allergies :	Height/Weight:	Gender: ☐ Male ☐ Female	
Address:	City:	State:	Zip:
Member ID #:	Plan Name:		

Prescriber Information

Prescribing Clinician:	Office Phone #:		
Specialty:	Office Secure Fax #:		
NPI #:	DEA/xDEA:		
Address:	City:	State:	Zip:
Contact Person (if different than provider):			
Prescriber's or Authorized Representative Signature:		**Date:**	

Medication Information

Medication Being Requested:

Strength: Quantity: Directions:

Diagnosis related to this request:

ICD Code(s):

If applicable, does the prescriber acknowledge or is aware that The American Geriatrics Society (AGS) considers the requested medication to be of high risk for patients 65 years old or older? ☐ Yes ☐ No

Is the patient currently enrolled in HOSPICE? ☐ Yes ☐ No

Previous Therapies Tried and/or Failed

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Failure

Additional information related to this request (lab values, non-pharmacologic therapies, contraindications, explanations for exceptions, etc):

☐ **By checking this box, I attest this is an *urgent case*, meaning that an expedited determination is necessary to prevent serious threat to life, limb, or eyesight; or threatens the body's ability to regain maximum function; or is needed to manage severe pain.**

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA