



PARTNERS
HEALTH PLAN



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.