



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/Requestor's Information

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 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).*