



## REQUEST FOR MEDICARE DRUG COVERAGE DETERMINATION

Use this form to ask our plan for a coverage determination. You can also ask for a coverage determination by phone at 855-344-0930. You, your doctor or prescriber, or your authorized representative can make this request.

### Plan Enrollee

Name	Date of birth
Street address	City
State	ZIP
Phone	Member ID #

### If the person making this request isn't the plan enrollee or prescriber:

Requestor's name
Relationship to plan enrollee
Street address (include City, State and ZIP)
Phone
<input type="checkbox"/> Submit documentation with this form showing your authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or equivalent). For more information on appointing a representative, contact our plan or call 1-800-MEDICARE. (1-800-633-4227). TTY users can call 1-877-486-2048.

**Name of drug this request is about** (include dosage and quantity information if available)

**Type of Request**

- My drug plan charged me a higher copayment for a drug than it should have
- I want to be reimbursed for a covered drug I already paid for out of pocket
- I'm asking for prior authorization for a prescribed drug (this request may require supporting information)

**For the types of requests listed below, your prescriber MUST provide a statement supporting the request.** Your prescriber can complete pages 3 and 4 of this form, "Supporting Information for an Exception Request or Prior Authorization."

- I need a drug that's not on the plan's list of covered drugs (formulary exception)
- I've been using a drug that was on the plan's list of covered drugs before, but has been or will be removed during the plan year (formulary exception)
- I'm asking for an exception to the requirement that I try another drug before I get a prescribed drug (formulary exception)
- I'm asking for an exception to the plan's limit on the number of pills (quantity limit) I can get so that I can get the number of pills prescribed to me (formulary exception)
- I'm asking for an exception to the plan's prior authorization rules that must be met before I get a prescribed drug (formulary exception).
- My drug plan charges a higher copayment for a prescribed drug than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception)
- I've been using a drug that was on a lower copayment tier before, but has or will be moved to a higher copayment tier (tiering exception)

Additional information we should consider *(submit any supporting documents with this form)*:

---

---

---

---

**Do you need an expedited decision?**

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we'll automatically give you a decision within 24 hours. If you don't get your prescriber's support for an expedited request, we'll decide if your case requires a fast decision. (You can't ask for an expedited decision if you're asking us to pay you back for a drug you already received.)

- YES, I need a decision within 24 hours.** If you have a supporting statement from your prescriber, attach it to this request.

<b>Signature:</b>	<b>Date:</b>
-------------------	--------------

## How to submit this form

Submit this form and any supporting information by mail or fax:

Address:  
CVS Caremark Part D, Appeals and Exceptions  
P.O. Box 52000, MC109  
Phoenix, AZ 85072-2000

Fax Number:  
1-855-633-7673

<b>Supporting Information for an Exception Request or Prior Authorization To be completed by the prescriber</b>
---

**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.

### Prescriber Information

Name	
Street Address (Include City, State and ZIP	
Office phone	
Fax	
Signature	Date

### Diagnosis and Medical Information

Medication:	Strength and route of administration:
frequency:	Date started: <input type="checkbox"/> <b>NEW START</b>
Expected length of therapy:	Quantity per 30 days:
Height/Weight:	Drug allergies:
<b>DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes</b> (If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)	ICD-10 Code(s)
<b>Other RELAVENT DIAGNOSES:</b>	ICD-10 Code(s)

**DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)**

<b>DRUGS TRIED</b> (if quantity limit is an issue, list unit dose/total daily dose tried)	<b>DATES of Drug Trials</b>	<b>RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)</b>

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

**DRUG SAFETY**

Any **FDA NOTED CONTRAINDICATIONS** to the requested drug?  **YES**  **NO**

Any concern for a **DRUG INTERACTION** when adding the requested drug to the enrollee's current drug regimen?  **YES**  **NO**

If the answer to either of the questions above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety

**HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY**

If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient?  **YES**  **NO**

**OPIOIDS – (answer these 4 questions if the requested drug is an opioid)**

What is the daily cumulative Morphine Equivalent Dose (**MED**)?  
**mg/day**

Are you aware of other opioid prescribers for this enrollee?  
If so, please explain.  **YES**  **NO**

Is the stated daily MED dose noted medically necessary?  **YES**  **NO**

Would a lower total daily MED dose be insufficient to control the enrollee's pain?  **YES**  **NO**

**RATIONALE FOR REQUEST**

**Alternate drug(s) previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** [If not noted in the DRUG HISTORY section, specify below: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed]

**Alternative drug(s) contraindicated, would not be as effective or likely to cause adverse outcome.** A specific explanation why alternative drug(s) would not be as effective or anticipated significant adverse clinical outcome and why this outcome would be expected is required. If contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated

**Patient would suffer adverse effects if he or she were required to satisfy the prior authorization requirement.** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required.

**Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

**Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]

**Request for formulary tier exception** If not noted in the DRUG HISTORY section, specify below: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

**Other** (explain below)

---

---

---

---

CHRISTUS Health Advantage is an HMO plan with a Medicare contract. Enrollment in CHRISTUS Health Advantage depends on contract renewal. CHRISTUS Health Advantage (HMO) contract #H1189.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844.282.3026 (TTY 711).

CHRISTUS Health Advantage is an HMO plan with a Medicare contract. Enrollment in CHRISTUS Health Advantage depends on contract renewal. This information is not a complete description of benefits. Open seven days a week, 8 a.m. to 8 p.m., local time, from October 1 – March 31, and Monday – Friday, 8 a.m. to 8 p.m., local time, from April 1 – September 30. Call 1.844.282.3026, TTY 711 for more information. A voice response system is available for after hours. Other providers are also available in our network. CHRISTUS Health Advantage (HMO) Contract #H1189.

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1.844.282.3026, TTY 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1.844.282.3026, TTY 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1.844.282.3026 (711) أو تحدث إلى مقدم الخدمة.

注意: 如果您说中文, 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1.844.282.3026 (文本电话: 711) 或咨询您的服务提供者。

ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1.844.282.3026, TTY 711 ou parlez à votre fournisseur.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1.844.282.3026, TTY 711 an oder sprechen Sie mit Ihrem Provider.

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્રિઝલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1.844.282.3026, TTY 711 પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1.844.282.3026, TTY 711 पर कॉल करें या अपने प्रदाता से बात करें।

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1.844.282.3026, TTY 711 o parla con il tuo fornitore.

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1.844.282.3026, TTY 711 までお電話ください。または、ご利用の事業者にご相談ください。

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1.844.282.3026, TTY 711 번으로 전화하거나 서비스 제공업체에 문의하십시오.

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1.844.282.3026, TTY 711 ຫຼື ວິມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

SHOOH: Diné bee yánittigogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jük'eh ná hólé. Bee ahit bane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anida'wo'i áko bee baa hane'í bee badadilyaa bich'i' ahoot'i'ígíí éí t'áá jük'eb hóló. Kohji' 1.844.282.3026, TTY 711 hodíilnih doodage nika'análwoi bich'i' hanidzih.

توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1.844.282.3026 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1.844.282.3026, TTY 711 или обратитесь к своему поставщику услуг.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1.844.282.3026, TTY 711 o makipag-usap sa iyong provider.

หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1.844.282.3026, TTY 711 หรือปรึกษาผู้ให้บริการของคุณ

توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1.844.282.3026, TTY 711 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

LU'U Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1.844.282.3026 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.