



of Tennessee

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MEDICARE PART D PRESCRIPTION DRUG AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

STANDARD REQUEST EXPEDITED REQUEST

GENERAL INFORMATION *Request Type (please check one)*

- Prior Authorization
 Step Therapy Exception
 Request Non-formulary Drug
 Request for Tiering Exception
 Request for Quantity Limit Exception
 Appeal

| | | | | | | | | | | |
|------------------------|-------|-----|----------------------------------|---|---|---|---|---|---|---|
| Patient Name | | | Date of Birth (mm/dd/yyyy) | | | | | | | |
| | | | M | M | D | D | Y | Y | Y | Y |
| Patient's Home Address | | | Contract Number (include prefix) | | | | | | | |
| | | | | | | | | | | |
| City | State | Zip | | | | | | | | |

PHYSICIAN INFORMATION

| | | | | | | | | |
|------------------|-------|-----|--|--|--|--|--|--|
| Physician Name | | | Practice Type | | | | | |
| | | | <input type="checkbox"/> PCP <input type="checkbox"/> Specialist | | | | | |
| Practice Address | | | Physician UPIN | | | | | |
| | | | | | | | | |
| City | State | Zip | Provider Number | | | | | |
| Office Phone | | | Office Fax | | | | | |
| | | | | | | | | |

TREATMENT INFORMATION

| | | |
|--|----------------------|----------------------------------|
| Drug Requested: | Dose Requested: | |
| Reason for Use: | | |
| ICD-9 Related to Use: | Duration of Disease: | |
| List other medication this patient has tried with this condition: | | |
| Drug: _____ | Regimen: _____ | Dates of Therapy: _____ to _____ |
| Drug: _____ | Regimen: _____ | Dates of Therapy: _____ to _____ |
| Drug: _____ | Regimen: _____ | Dates of Therapy: _____ to _____ |
| Does this patient have any co-morbid conditions that will affect therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If so, please list: _____ | | |
| _____ | | |

I certify this information is correct. I understand that intentional misrepresentation of information herein may constitute fraud and be subject to legal action.

Recertification is required annually. Physician Signature _____ Date _____

SUBMISSION INSTRUCTIONS

PCSI-02 (12-2006)
H5884/H5880

FAX

You may fax the signed and completed form to Pharmacy Review at: **205 220-9575**

MAIL

You may mail the signed and completed form to:
Part D Authorization Requests
Attention : Pharmacy Review
P.O. Box 12485 • Birmingham Alabama 35202-2485