



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 Name 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
Phone			

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

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PRESCRIBING PHYSICIAN'S INFORMATION

Name		Medical Specialty	
Address	City	State	Zip
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).*
- I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*
- I request prior authorization for the drug my doctor has prescribed.

