



1205 S.W. 37<sup>th</sup> Avenue, 2<sup>nd</sup> Floor, Miami, FL 33135  
 Tel: 305-448-8100 Fax: 305-448-5783

## Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- **Biotech or other specialty drugs for which drug-specific forms are required.** [See <Part D plan website.>] OR [See links to plan websites at [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04\\_Formulary.asp](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp)]

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name: Dr.		
Member ID#:		NPI# (if available):		
Address:		Address:		
City:	State: FL	City:	State: FL	
Home Phone:	Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle):    M        F	DOB:			

Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:	Frequency:	
New Prescription or Date Therapy Initiated:	Expected Length of Therapy:	Qty:	
Height/Weight:	Drug Allergies:	Diagnosis:	
Prescriber's Signature:			Date:

**Rationale for Exception Request or Prior Authorization  
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION**

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)  
     ➔ Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);
- Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change  
     ➔ Specify below: Anticipated significant adverse clinical outcome
- Medical need for different dosage form and/or higher dosage  
     ➔ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason
- Request for formulary tier exception  
     ➔ Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome
- Other: \_\_\_\_\_ ➔ Explain below

**REQUIRED EXPLANATION:** \_\_\_\_\_

**Request for Expedited Review**

- REQUEST FOR EXPEDITED REVIEW [24 HOURS]  
     ➔ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION
- HEALTHSUN DIRECTOR OF MEDICAL SERVICES SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_  
 OR DESIGNEE: \_\_\_\_\_ DATE: \_\_\_\_\_