

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:	Fax Number:
Catamaran	1-(866)-391-2929
2441 Warrenville Road, Suite 610	
Lisle, IL 60532-3642	

You may also ask us for a coverage determination by phone at 1-(866)-235-1793 or through our website at www.BCBSRI.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

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

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 prior authorization for the drug my prescriber has prescribed.*
- ☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
- ☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*
- ☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- ☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- ☐ My drug plan charged me a higher copayment for a drug than it should have.
- ☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider (*attach any supporting documents*):

Important Note: Expedited Decisions

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 will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for

an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature:	Date:
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Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ **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's Information

Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information

Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:

Rationale for Request

- ☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., 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)]
- ☐ **Patient 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** _____
- _____
- _____
- _____

Analgesics Prior Authorization Criteria

You must answer ALL of the following questions

1. Is the patient enrolled in a Medicare-approved hospice program?	Y	N
2. The requested drug is considered a high-risk medication for elderly patients (age 65 and older). Do you wish to proceed with the originally prescribed medication?	Y	N
3. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> Mild pain: acetaminophen, codeine. Moderate to severe pain: short-term NSAIDs, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, fentanyl. Neuropathic pain: duloxetine, pregabalin, gabapentin, desipramine, nortriptyline, topical agents (capsaicin, topical lidocaine) 		
4. What is the patient's diagnosis? Please document: _____		

Anti-arrythmics, Antihistamines, Antiparkinson's, Estrogens and Progestins and Skeletal Muscle Relaxants Prior Authorization Criteria

You must answer ALL of the following questions		
1. The requested drug is considered a high-risk medication for elderly patients (age 65 and older). Do you wish to proceed with the originally prescribed medication?	Y	N
2. What is the patient's diagnosis? Please document: _____		

Antidepressants Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> TCA: nortriptyline, desipramine, low-dose doxepin, trazodone. Depression: SSRI, SNRI, mirtazapine, bupropion. duloxetine, pregabalin, gabapentin, capsaicin. Insomnia: sleep hygiene therapy, melatonin, ramelteon (8 mg/d), low-dose doxepin (less than or equal to 6mg/d) 		
3. What is the patient's diagnosis? Please document: _____		

Anti-emetics Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the patient enrolled in a Medicare-approved hospice program?	Y	N
2. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
3. What is the patient's diagnosis? Please document: _____		

Antihypertensives Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions. 		
3. What is the patient's diagnosis? Please document: _____		

Antipsychotics Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> Haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone 		
3. What is the patient's diagnosis? Please document: _____		

Anxiolytics Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the patient enrolled in a Medicare-approved hospice program?	Y	N
2. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
3. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> Anxiety: SSRI, SNRI, buspirone. Insomnia: sleep hygiene therapy, melatonin, ramelteon (8 mg/d), low-dose doxepin (less than or equal to 6mg/d). 		
4. What is the patient's diagnosis? Please document: _____		

Antidementia Agents Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> donepezil, galantamine, rivastigmine, memantine 		
3. What is the patient's diagnosis? Please document: _____		

Calcium Channel Blockers Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> extended-release nifedipine, nicardipine, amlodipine 		
3. What is the patient's diagnosis? Please document: _____		

Oncology Agents Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. What is the patient's diagnosis? Please document: _____		

Platelet Inhibitors Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> • clopidogrel, dipyridamole, low-dose aspirin 		
3. What is the patient's diagnosis? Please document: _____		

Sedative Hypnotics Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) when used longer than 90 days and wishes to proceed with the originally prescribed medication?	Y	N
2. What is the patient's diagnosis? Please document: _____		

Sulfonylureas Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> • glimepiride, glipizide 		
3. What is the patient's diagnosis? Please document: _____		

Thyroid Agents Prior Authorization Criteria

You must answer ALL of the following questions		
1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle	Y	N
<ul style="list-style-type: none"> • levothyroxine, levoxyl 		
3. What is the patient's diagnosis? Please document: _____		

Vasodilators Prior Authorization Criteria

You must answer ALL of the following questions

1. Is the prescriber aware that the requested drug is considered a high-risk medication for elderly patients (age 65 and older) and wishes to proceed with the originally prescribed medication?	Y	N
2. Has the patient tried and had an inadequate response to at least one non-HRM alternative listed below? Please Circle <ul style="list-style-type: none">• clopidogrel, low-dose aspirin	Y	N
3. What is the patient's diagnosis? Please document: _____		