blue california | promise HEALTH PLAN

Medicare Part D Prescription Coverage Request Form

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Important Note: Expedited Decisions

If the standard decision time of 72 hours or less may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited (fast) decision can be requested.

☐ CHECK THIS BOX IF A DECISION NEEDS TO BE GIVEN WITHIN 24 HOURS.

Date of Request:

Physician Information	**Patient Information**
Physician's Name: ☐ PCP; ☐ Specialist: _____ Office contact: Phone#: Facsimile #:	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: Patient's height/weight: Drug Allergies:

DRUG REQUESTED:	QUANTITY:

STRENGTH:	DIRECTIONS:

DIAGNOSIS:	ICD-10 CODE:	EXPECTED LENGTH OF THERAPY:

Type of coverage determination requested *(please check the appropriate box)*

☐ Prior Authorization

☐ Request for a drug that is not on the plan's list of covered drugs (formulary exception)

☐ Request an exception to the requirement that another drug is tried before receiving the drug prescribed (formulary exception).

☐ Request an exception to the plan's limit on the number of pills (quantity limit) that can be received at one time (formulary exception).

☐ Request to lower the copayment for a drug that has been prescribed (tiering exception).

1. Is this new a new prescription? ☐ Yes ☐ No. If no, please provide date therapy was started.

FAX form to: 1(323)889-6254 or 1(866)712-2731	**Pharmacy Services Phone #: 1(877)792-2731**

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

_____
_____
_____
_____
_____
_____

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

Provider 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

_____
_____
_____
_____
_____
_____
_____

Provider Signature:	**Date:**

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