



**National Rural Electric
Cooperative Association**

A Touchstone Energy® Cooperative

MAIL OR FAX TO:

**Caremark Appeals Dept.
PO Box 52000, MC 109, Phoenix, AZ 86072-2000
Fax: 866.884.9475 (standard and expedited)
Phone: 866.586.7322 (expedited-fast-only)**

NRECA MEDICARE PART D PRESCRIPTION DRUG PLANS COVERAGE DETERMINATION REQUEST FORM

To be completed by Patient, Requestor or Physician:

Standard or Expedited (Fast) Request Check One:	<input type="checkbox"/> STANDARD REQUEST 72 HRS <i>Non-emergency medical situations</i>	<input type="checkbox"/> EXPEDITED (FAST) REQUEST 24 HRS <i>Emergency medical situations only</i> (Must provide physician supporting statement)
Type of Coverage Determination Request Check All That Apply: <i>(Plan may request additional information)</i>	<input type="checkbox"/> FORMULARY EXCEPTION <i>(Must provide physician supporting statement):</i> Drug not on formulary, or drug removed from formulary, and should be covered.	
	<input type="checkbox"/> TIERING EXCEPTION <i>(Must provide physician supporting statement):</i> I want to get the non-preferred brand name drug my doctor prescribed at the lower tier copayment of the Copayment plan's preferred brand name drugs. <i>Note: only applies to the Copayment Plan.</i>	
	<input type="checkbox"/> QUANTITY EXCEPTION <i>(Must provide physician supporting statement):</i> I request an exception to the plan's quantity limit so that I can get the quantity my doctor prescribed.	
	<input type="checkbox"/> PAYMENT FOR DRUG: (1) I paid for the drug because the Plan said it was not covered and I believe it was, (2) the Plan covered the drug but paid too little or I paid too much, or both.	
Do not use this form for Prior Authorizations	<input type="checkbox"/> DRUG COVERAGE: (1) Out-of-network coverage (2) Exclusion from coverage (3) Delay in decision (4) Other <i>(specify):</i>	

PATIENT/REQUESTOR INFORMATION

To be completed by Patient, Requestor or Physician:

Patient Name (or Requestor Name if not Patient) _____ Patient Date of Birth _____ Patient Medicare Number (HIC#) _____

Sex: Male Female

Patient Part D Plan ID Basic Basic Plus Copayment Enhanced Enhanced Plus

Patient/Requestor Address _____ Requestor's Relationship to Patient _____
(Must provide authorization form or other documentation)

City _____ State _____ Zip Code _____ Phone (_____) _____ Fax (_____) _____

SIGNATURE AND DATE

PRINTED NAME – Patient / Representative / Physician _____

SIGNATURE – Patient / Representative / Physician _____

DATE _____

Your physician should complete the second page of this form when a physician's supporting statement is required or when medical information in support of the coverage determination request may be necessary or helpful.

PHYSICIAN INFORMATION

To be completed by Physician:

Physician Name _____ Medical Specialty _____ NPI # (if available) _____
Physician/Practice/Facility Address _____ Office Contact Person _____
City _____ State _____ Zip Code _____ Phone (_____) _____ Fax (_____) _____

DIAGNOSIS / MEDICAL INFORMATION

To be completed by Physician:

New prescription? Yes No

Medication _____ Strength and Route of Administration _____ Frequency of Use _____
Date Therapy Initiated _____ Expected Length of Therapy _____ Quantity _____
Height/Weight _____ Drug Allergies _____ Diagnosis _____

MEDICAL RATIONALE FOR REQUEST

To be completed by Physician:

- 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)
- 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 or therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome.

PHYSICIAN SUPPORTING STATEMENT / ADDITIONAL INFORMATION

To be completed by Physician (*Attach additional pages and supporting documentation as necessary or requested*):

SIGNATURE AND DATE

- Must Check this Box for Expedited Requests.** I certify that the patient needs an expedited coverage determination (attach physician's supporting statement). If I have checked this box and signed below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the patient or his/her ability to regain maximum function.

Physician's Name _____ Physician's Signature _____ Date _____

Information on this form is protected health information subject to all privacy and security regulations under HIPAA. This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for cosmetic purposes or hair growth, over-the-counter drugs, drugs used for relief of coughs or colds, or prescription vitamins (except prenatal vitamins and fluoride preparations).