



**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.
Visit www.SilverScript.com for a complete formulary listing.

SECTION I: BENEFICIARY INFORMATION

LAST NAME, FIRST NAME (PLEASE PRINT)	DOB (MM/DD/YYYY)
STREET ADDRESS	PHONE NUMBER (AREA CODE)
CITY, STATE	ZIP CODE
SEX (circle) M or F	CARDHOLDER ID #

SECTION II: PRESCRIBER INFORMATION

LAST NAME, FIRST NAME (PLEASE PRINT)	PHONE NUMBER (AREA CODE)
STREET ADDRESS	FAX NUMBER (AREA CODE)
CITY, STATE	NPI # (if available)
ZIP CODE	CONTACT PERSON

SECTION III: DIAGNOSIS and MEDICAL INFORMATION

MEDICATION NAME	MEDICATION STRENGTH	FREQUENCY OF USE
DATE THERAPY INITIATED	EXPECTED LENGTH OF THERAPY	QUANTITY
HEIGHT/WEIGHT	DRUG ALLERGIES	DIAGNOSIS
PRESCRIBER'S SIGNATURE	DATE	

Rationale for Exception Request for Prior Authorization Form

- Alternative 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 outcomes for each; (3) if therapeutic failure, length of therapy of 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(s)
- Medical need for different dosage form and/or high dosage
 - ▶ ***Specify below:** (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reasons
- 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
- Other: _____
 - ▶ ***Explain below**

***REQUIRED EXPLANATIONS:** _____

***THIS FORM WILL NOT BE PROCESSED WITHOUT THE REQUIRED EXPLANATIONS ABOVE!**

Request for Expedited Review

- Request for expedited review
 - ▶ **By checking this box and signing above, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life and health of the beneficiary or the beneficiary's ability to regain maximum function**

Please complete the ENTIRE form and return in to the following address or fax number:

SilverScript
Appeals Department – MC109
P.O. Box 52000
Phoenix, AZ 85072-2000
Fax Number: (866) 884-9475

Information on this form is protected health information and subject to all privacy and security regulations under HIPPA