Santa Clara Family Health Plan™

MedImpact

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San Diego, CA 92131

Phone: (800) 788-2949
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Medicare Part D Coverage Determination Request Form

This form **cannot** be used to request:

- Medicare non-covered drugs, including 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).

Plan Name:

Patient Information		**Prescriber Information**		
Patient Name:		Prescriber name:		
Member ID#:		DEA#		
Address:		Address:		
City:	State:	City:		State:
Home Phone:	Zip:	Office Phone:	Office Fax:	Zip:
Sex (circle): M F	DOB:	Contact Person:		

Diagnosis and Medical Information		
Medication:	Directions for use: (Frequency & Strength):	
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy: Route of Administration	Qty: Qty per month:
Height/Weight:	Drug Allergies:	Diagnosis:
Prescriber's Signature:	MD Specialty:	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 (i.e., 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
- 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 ABILITYTO REGAIN MAXIMUM FUNCTION

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA