Request for a Medicare Part D Prescription Drug Coverage Determination

UPREHS Prime Medicare Plan
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421
Fax: 801-595-2037

UPREHS may require additional information. Refer to your UPREHS Prime Medicare Plan Benefit Guide for more information. Return this request to the address above.

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, erectile dysfunction, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations) which are non-covered under Medicare Part D.

Member/Requestor's Information

Member Name ____________________________________ Date of Birth ________________________
(MM/DD/YYYY)

UPREHS ID Card # ________________________________ Medicare # ___________________________

Requestor's Name (if not member)__________________________ Phone (___) ___________________

Requestor's Relationship to Member ____

Attach documentation that shows authority to represent enrollee if other than the prescribing physician. See Appointment of Representative Form (CMS form 1696).

Member/Requestor Address ____

City, State, Zip ____

Prescribed Drug Name ____

If known, include: Strength _________________ Quantity ______________ Days Supply _______

Prescribing Physician's Information

Physician Name ___________________________________ Medical Specialty_____________________

Phone (____)_________________ Fax (____) _________________ Office Contact __________________

Physician Address____

Physician City, State, Zip ____

Form continues on following page.

Request for a Medicare Part D Prescription Drug Coverage Determination (continued)

Check the type of determination below that you are requesting:

☐ I need a drug that I believe is covered by Medicare Part D, but is not on the UPREHS Preferred Formulary (formulary exception). *

☐ I request prior authorization for the Medicare Part D drug my doctor has prescribed.

☐ I request an exception to the UPREHS plan limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor has prescribed (formulary exception). *

☐ UPREHS charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception). *

☐ 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 PRESCRIBING physician must provide a statement to support your request. The type of information UPREHS requires from your physician is found on the form titled *Physician Documentation Form for an Exception Request or a Compounded Drug*. You cannot ask for a tiering exception for a drug in the UPREHS formulary Tier 1, 2 or 4, or on a drug that you have already received or been allowed under a formulary exception. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs (Tier 1).

Additional information we should consider (attach any supporting documents) OR other request:

____

____

____

____

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided to you within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for your, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

☐ I need an expedited (fast) coverage determination (attach your prescribing physician's supporting statement if applicable).

____ _______________________________

Member/Requestor Signature Date

COVDETREQFORME731620071208EOC

PO Box 161020 / Salt Lake City, Utah 84116-1020 / Phone (800) 547-0421 / Fax (801) 595-4399