

HealthChoice

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

This form can be returned to HealthChoice by mail or fax:

Address:
OSEEGIB, Attn: Pharmacy Unit
3545 N.W. 58 Street, Suite 110
Oklahoma City, OK 73112

Fax Number:
1-405-717-8925

Who Can Make a Request for Me? Your prescriber can ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Member's Information

Member's Name _____ Date of Birth _____

Member's Address _____

City _____ State _____ Zip Code _____

Phone _____ HealthChoice ID # _____

Complete the following section ONLY if the person making this request is not the enrollee or prescriber. You must attach a completed Authorization of Representation Form CMS-1696 (available on this website) or a written equivalent showing the authority to represent the member. For more information on appointing a representative, contact HealthChoice or Medicare at 1-800-Medicare.

Requestor's Name _____

Requestor's Relationship to Member _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Prior Authorization (Coverage Determination Request)

- I need a drug that is not on the HealthChoice Medicare Formulary (non-formulary exception).*
- I have been using a drug that was previously included on the HealthChoice Medicare Formulary, but it is being removed or was removed from the formulary during the plan year (formulary exception).*
- I request prior authorization for the drug my prescriber has prescribed.*
- I request an exception to the Step Therapy requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
- I request an exception to the plan's limit on the number of pills (Quantity Limits) I can receive so I can get the number of pills or fills my prescriber prescribed (formulary exception).*
- HealthChoice charges a higher copay for my prescribed drug than it charges for another drug that treats my condition. I want an exception to pay the lower copayment (tier exception).*
- I have been taking a drug that was previously on a lower copay tier, but it is being moved to or was moved to a higher copay tier (tier exception).*
- HealthChoice charged me a higher copay for a drug than it should have.
- I want to be reimbursed for a covered drug that I paid for out of my own pocket.

***NOTE: If you ask for a formulary or tier exception, your prescriber MUST provide a statement supporting your request. Your prescriber can use the attached document, *Supporting Information for a Prior Authorization* to provide information that supports your request for an exception.**

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

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for a fast decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for a fast decision, we will decide if your case requires a fast decision. You cannot request a fast decision if you are asking us to pay you back for a drug you already received.

CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS. (You must have a supporting statement from your prescriber attached to this request.)

Signature of the person requesting the prior authorization (coverage determination), i.e., the enrollee, the enrollee's prescriber, or appointed representative):

_____ **Date:** _____

Supporting Information for an Exception Request or Prior Authorization

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

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of my patient or their ability to regain maximum function.

Prescriber's Information			
Prescriber's Name _____			
Prescriber's Address _____			
City _____	State _____	Zip Code _____	
Office Phone _____	Fax _____		
Prescriber's Signature _____			Date _____

Diagnosis and Medical Information			
Medication:		Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

Reason 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
- 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 or 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: _____
