<Plan Logo>

<Plan Mailing Address>
<Plan Phone Number>
<Plan Fax Number>

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. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]**

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name: Matthew G Schuermann, MD		
Member ID#:		NPI# (if available): 1306816970		
Address:		Address: 6239 Cheviot Rd		
City:	State:	City: Cincinnati		State: OH
Home Phone:	Zip:	Office Phone #: 513-325-0398	Office Fax #: 513-385-3952	Zip: 45247
Sex (circle): M F	DOB:	Contact Person: Christy		

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
Prescriber's Signature:		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 (eg, 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 [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 ABILITY TO REGAIN MAXIMUM FUNCTION

<HIPAA Disclaimer>