



4350 E. Cotton Center Boulevard
 Building D
 Phoenix, AZ 85040
 Phone (602) 263-3000
 Toll Free (800) 624-3879

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Enrollee's/Requestor's Information (Please print)

Enrollee Name		Date of Birth	
Enrollee Health Plan ID#		Medicare Health Insurance Number	
Requestor's Name (if not enrollee)*		Requestor's Relationship*	
Address 1	City	State	Zip Code
Address 2	Telephone		

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

Prescribing Physician's Information

Physician Name		Medical Specialty	
Address	City	State	Zip
Office Telephone	FAX	Contact Person	

Type of Coverage Determination Request

Check One

- I need a drug that is not on the plan's list of covered drugs (formulary exception). **
- I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception). **
- I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed. **
- I request prior authorization for the drug my doctor has prescribed.
- I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception). **
- I want to be reimbursed for a covered prescription drug that I paid for out of my pocket. (Must



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submit any detailed pharmacy receipts.)

****NOTE:** If you are asking for a formulary exception, your **PRESCRIBING PHYSICIAN** must provide a statement to support your request. We cannot begin to review your coverage determination request until we receive your prescribing physician's statement.

Additional Information

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm the life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a fast decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees, 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 coverage determination (attach physician's supporting statement, if applicable).

Enrollee/Requestor* signature	Date
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*Requestor must attach documentation that shows authority to represent enrollee, if other than prescribing physician.

If you need additional information, please contact Member Services at (602) 263-3000 or toll free at (800) 624-3879. TTY/TDD Users should call (866) 602-1982. We are available 24 hours a day, 7 days a week.

Submit this form and any supporting documentation to:

**Mercy Care Advantage
 Attn: Pharmacy Prior Authorization Unit
 4350 E. Cotton Center Blvd., Bldg D
 Phoenix, AZ 85040**

Pharmacy Fax Number: (800) 871-6898

For additional information on the coverage determination process, please see your Evidence of Coverage. Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.