NRECA Employee Benefits

Medicare Part D
Coverage Decision Request Form

National Rural Electric Cooperative Association
A Touchstone Energy® Cooperative

NRECA Medicare Part D
PRESCRIPTION DRUG PLANS
an Employer PDP

MedicareRx
Prescription Drug Coverage

To be completed by patient, requestor or physician
Do not use this form for Prior Authorizations.

Standard or Expedited (Fast) Request. Check one.

☐ **Standard Request 72 HRS**
Non-emergency medical situations

☐ **Expedited (Fast) Request 24 HRS**
Emergency medical situations only. Must provide physician supporting statement.

Type of Coverage Decision Request. Check all that apply.
Plan may request additional information.

☐ **Formulary Exception** (Must provide physician supporting statement): Drug not on formulary, or drug removed from formulary, and should be covered.

☐ **Tiering Exception** (Must provide physician supporting statement): I want to get the non-preferred brand name drug my doctor prescribed at the lower tier copayment of the Copayment Plan's preferred brand name drugs. Note: only applies to the Copayment Plan.

☐ **Step Therapy** (Must provide physician supporting statement): I request an exception to the plan's step therapy requirements so that I can get the drug my doctor prescribed without having to take another drug first.

☐ **Quantity Exception** (Must provide physician supporting statement): I request an exception to the plan's quantity limit so that I can get the quantity my doctor prescribed.

☐ **Payment For Drug:** (1) I paid for the drug because the Plan said it was not covered and I believe it was, (2) the Plan covered the drug but paid too little or I paid too much, or both.

☐ **Drug Coverage:** (1) Out-of-network coverage (2) Exclusion from coverage (3) Delay in decision
(4) Other (specify): _____

Patient/Requestor Information

Patient Name (or Requestor Name if not Patient)	Patient Date of Birth	Patient Medicare Number (HIC#)

Patient Part D Plan ID: ☐ Basic ☐ Basic Plus ☐ Copayment ☐ Enhanced ☐ Enhanced Plus

Gender ☐ Male ☐ Female	Patient/Requestor Address			Phone
City		State	ZIP	Fax

Requestor's Relationship to Patient (Must provide authorization form or other documentation)

Signature and Date

Printed Name – Patient/Representative/Physician

Signature – Patient/Representative/Physician	Date

Your physician should complete the second page of this form when a physician's supporting statement is required or when medical information in support of the coverage decision request may be necessary or helpful.

Physician Information – To be completed by Physician			
Physician Name	Medical Specialty	NPI# (if available)	
Physician/Practice/Facility Address	City	State	ZIP
Office Contact Person	Phone	Fax	

Diagnosis/Medical Information – To be completed by Physician			
Medication	Strength and Route of Administration	Frequency of use	New prescription? ☐ Yes ☐ No
Date Therapy Initiated	Expected Length of Therapy	Quantity	
Height/Weight	Drug Allergies	Diagnosis	

Medical Rational For Request – To be completed by Physician

☐ 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(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 or therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Physician Supporting Statement/Additional Information – To be completed by Physician

Attach additional pages and supporting documentation as necessary or requested.

Signature and Date

☐ **Must Check This Box for Expedited Requests.** I certify that the patient needs an expedited coverage decision (attach physician's supporting statement). If I have checked this box and signed below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the patient or his/her ability to regain maximum function.

Physician's Name (Print)	Physician's Signature	Date

Mail to:
NRECA Part D Plans (Employer PDP)
Appeals Dept., MC 109
P.O. Box 52000
Phoenix, AZ 85072-2000

Call or fax to:
Phone: 1-866-586-7322 (expedited-fast-only)
Fax (prior authorizations): 1-866-239-8303 (standard and expedited)
Fax (other requests): 1-866-239-8303 (standard and expedited)

Information on this form is protected health information subject to all privacy and security regulations under HIPAA. This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for cosmetic purposes or hair growth, over-the-counter drugs, drugs used for relief of coughs or colds, or prescription vitamins (except prenatal vitamins and fluoride preparations).