

NARBHA PM FORM 3.16.9

Form developed by CMS, American's Health Insurance Plans (AHIP) and American Medical Association (AMA)- May 2006

Plan Name: _____

Phone # _____

Fax # _____

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: <i>Psychiatric Group for</i>		
Member ID# (Medicare):		NPI# (if available): <i>N/A</i>		
Address:		Address:		
City:	State: AZ	City:	State: AZ	
Home Phone:	Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle): <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Contact Person:		
Diagnosis and Medical Information				
Medication:	Strength and Route of Administration: _____ <input type="checkbox"/> <i>titration may require multiple strengths:</i>		Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:	Expected Length of Therapy: <input type="checkbox"/> UNDETERMINED, DUE TO PSYCH DX <input type="checkbox"/> <i>Other:</i>		Qty: (<i>monthly supply</i>)	
Height/Weight:	Drug Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> <i>Other:</i>			
Diagnosis: <input type="checkbox"/> Schizophrenia 295.60 <input type="checkbox"/> Schizoaffect. 295.70 <input type="checkbox"/> MDD 296.30 <input type="checkbox"/> Bipolar 269.80 <input type="checkbox"/> Bipolar II 296.89 <input type="checkbox"/> PTSD 309.81 <input type="checkbox"/> BorderPD 301.83 <input type="checkbox"/> ADHD 314.01 <input type="checkbox"/> GAD 300.02 <input type="checkbox"/> Panic 300.21 <input type="checkbox"/> Alcohol Dep 303.90 <input type="checkbox"/> MR/DD <input type="checkbox"/> Dementia <input type="checkbox"/> <i>Other</i> _____ Severity: <input type="checkbox"/> mild <input type="checkbox"/> mod <input type="checkbox"/> severe <input type="checkbox"/> recurrent <input type="checkbox"/> single				
Prescriber's Signature:			Date:	
Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION				
<input type="checkbox"/> 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) <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> Other: _____ → Explain below REQUIRED EXPLANATION: <input type="checkbox"/> <u>As per CMS Formulary Guidance Document 3/7/06, beneficiaries receiving antidepressants, antipsychotics and anticonvulsants should be permitted to continue utilizing these meds if providing clinically beneficial outcomes.</u> <input type="checkbox"/> <u>Has had beneficial outcome to this medication prior to enrollment on Plan.</u> <input type="checkbox"/> <u>Has tried and failed multiple regimens.</u> <input type="checkbox"/> <u>Complex beneficiary due to psychiatric illness.</u> <input type="checkbox"/> <u>Significant drug-drug interactions possible.</u> <input type="checkbox"/> <u>Interruption of therapy could cause significant negative outcomes in short time frame due to nature of mental illness including deterioration, treatment noncompliance and hospitalization.</u> <input type="checkbox"/> <u>Proposed medication and dosage are standard/best practice for this disorder and this patient.</u> <input type="checkbox"/> <u>CMS (3/7/06) does not expect Plans to use utilization mgmt tools, like PA/tiers/steps, for persons on psychotropic meds.</u> <input type="checkbox"/> Other: _____				
Request for Expedited Review				
<input type="checkbox"/> 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				

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.