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CRTR

2024 Request for Medicare Prescription Drug Coverage Determination

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(You must complete both pages.)

Fax completed form to: 1-800-408-2386 **For urgent requests, please call: 1-800-414-2386**

Patient information		**Prescriber information**		
Patient name		Today's date	Physician specialty	
Patient insurance ID number		Physician name		NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP		
Patient home telephone number		M.D. office telephone number		
Gender ☐ Male ☐ Female	Patient date of birth	M.D. office fax number		
Diagnosis and medical information				
Medication requested		Strength and route of administration		Frequency
New prescription OR date therapy initiated		Quantity	Day supply	Expected length of therapy
Diagnosis (*Please include all office notes supporting diagnosis.)*				

Please check all boxes that apply:

1. **Check the box that best describes medication administration location:**
   - ☐ Patient's home or assisted living facilities
   - ☐ Long Term Care Facilities (LTC)/Skilled Nursing Facilities (SNF)
   - ☐ Ambulatory Infusion Center (infusion center supplies drug)
   - ☐ Ambulatory Infusion Center (retail/outpatient pharmacy supplies drug)
   - ☐ Office administered (pharmacy supplies drug)
   - ☐ Office administered (office supplies drug) /J CODE: _____
   - ☐ Other (explain): _____

2. ☐ **Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in an adverse clinical outcome.**

3. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.**

4. **The American Geriatric Society recommends avoiding high risk medications (HRM) in the elderly as a safety concern. To ensure safe use of potentially high risk medications (HRM) in the elderly population, prescriber must acknowledge that medication benefits outweigh potential risks in the elderly.** *Note: Members under 65 years of age are not subject to the prior authorization requirements.*
   - ☐ The requested medication is medically necessary and the clinical benefits outweigh the risks for this specific patient.

5. ☐ **Yes** ☐ **No** **Does patient have a diagnosis of cancer?**

6. ☐ **Yes** ☐ **No** **Is the patient on dialysis?**

7. **Complete this section if the requested drug is an immunosuppressant being used to prevent transplant rejection:**
   - ☐ What was the date of the patient's transplant (mm/dd/yy)? _____/_____/_____

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Please check all boxes that apply *(continued)*:

8. **Complete this section if the requested drug is being used in a nebulizer (inhalation solutions i.e albuterol, ipratropium, Tobi etc.) or an infusion pump (insulin vials, morphine infusion, chemotherapy for liver cancer etc.):**

☐ The patient resides in one of the following long-term care (LTC) facilities:

- A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF)
- A Medicaid-only NF that primarily furnishes skilled care, a non-participating nursing home (i.e. neither Medicare nor Medicaid) that provides primarily skilled care, an institution which has a distinct part SNF and which also primarily furnishes skilled care

☐ The patient resides in his or her own home **OR**

☐ The patient resides in an assisted living facility **OR**

☐ The patient resides at other locations not listed here; provide the name, phone number and address:

_____

_____

9. ☐ Yes ☐ No **Does patient require higher dosage (quantity limit exception)?**

►If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day

☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

☐ The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

10. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

11. ☐ **Other supporting information**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

_____

_____

_____

_____

_____

_____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	**Date**