REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:  
Express Scripts  
Attn: Medicare Reviews  
P.O. Box 66571  
St. Louis, MO 63166-6571

Fax Number: 1.877.251.5896

You may also ask us for a coverage determination by phone at 1.800.935.6103 or through our website at www.Express-Scripts.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee’s Information

<table>
<thead>
<tr>
<th>Enrollee’s Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee’s Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone</td>
<td>Enrollee’s Member ID #</td>
</tr>
</tbody>
</table>

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor’s Name

Requestor’s Relationship to Enrollee

Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td></td>
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</table>

Representation documentation for requests made by someone other than enrollee or the enrollee’s prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.
Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

☐ 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 prior authorization for the drug my prescriber has prescribed.*
☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
☐ 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 prescriber prescribed (formulary exception).*
☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
☐ My drug plan charged me a higher copayment for a drug than it should have.
☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

*NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement) may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.

Additional information we should consider (attach any supporting documents):

Important Note: Expedited Decisions

If you or your prescriber believes that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescribers support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Signature: Date:
FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber’s supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

<table>
<thead>
<tr>
<th>Prescriber’s Information</th>
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<tbody>
<tr>
<td>Name</td>
<td></td>
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<tr>
<td>Address</td>
<td></td>
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<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Office Phone</td>
<td>Fax</td>
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<tr>
<td>Prescriber’s Signature</td>
<td>Date</td>
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<table>
<thead>
<tr>
<th>Diagnosis and Medical Information</th>
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<tbody>
<tr>
<td>Medication:</td>
<td>Strength and Route of Administration:</td>
</tr>
<tr>
<td>New Prescription OR Date</td>
<td>Expected Length of Therapy:</td>
</tr>
<tr>
<td>Therapy Initiated:</td>
<td></td>
</tr>
<tr>
<td>Height/Weight:</td>
<td>Drug Allergies:</td>
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<tr>
<th>Rationale for Request</th>
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<tr>
<td>☐ 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)]</td>
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</tr>
<tr>
<td>☐ Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change [Specify below: Anticipated significant adverse clinical outcome]</td>
<td></td>
</tr>
<tr>
<td>☐ 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]</td>
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</tr>
<tr>
<td>☐ 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]</td>
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<tr>
<td>☐ Other (explain below)</td>
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Required Explanation

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Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at 612-676-3200 (voice) or toll free at 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the number on the back of your membership card or 612-676-3200 or toll free at 1-800-203-7225 (voice); 612-676-6810 or toll free at 1-800-688-2534 (TTY).

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call 612-676-3200 or toll free at 1-800-203-7225 (voice); 612-676-6810 or toll free at 1-800-688-2534 (TTY). You can also use these numbers if you need assistance filing a grievance.

Written grievance

Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-6500/1-866-457-7144（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-6500/1-866-457-7144 (телетайп: 612-676-6810/1-800-688-2534).

โปรด注意：ท่านสามารถขอคำปรึกษาทางภาษา อังกฤษ ได้โดยไม่เสียค่าบริการ ที่หมายเลข 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534)。


APIITANGA: Ngang! Ang apana ang gicperhapsite ng panasuy, magpakita sa dumaan ng maayos na serbisyo sa pag-apat ng kultura ng bayan, ang apana ang gicpapawid sa kinapalit na alipin. Tumawag 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534)

specified: If you have any language services, you can call for free translation services at 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

