REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

<table>
<thead>
<tr>
<th>Address:</th>
<th>Fax Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Express Scripts</td>
<td>1.877.251.5896</td>
</tr>
<tr>
<td>Attn: Medicare Reviews</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 66571</td>
<td></td>
</tr>
<tr>
<td>St. Louis, MO 63166-6571</td>
<td></td>
</tr>
</tbody>
</table>

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](http://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></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollee’s Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Enrollee’s Member ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Requestor’s Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requestor’s Relationship to Enrollee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</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>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Office Phone</td>
</tr>
<tr>
<td>Prescriber’s Signature</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis and Medical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
</tr>
<tr>
<td>New Prescription OR Date Therapy Initiated:</td>
</tr>
<tr>
<td>Height/Weight:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale for Request</th>
</tr>
</thead>
<tbody>
<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>
</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>
</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>
</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>
</tr>
<tr>
<td>☐ Other (explain below)</td>
</tr>
</tbody>
</table>

Required Explanation

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Supporting Information for an Exception Request or Prior Authorization
Attention. If you need free help interpreting this document, call the above number.

النقطة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

Hubachiisa. Dokumenttiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kename bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.
Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Auxiliary Aids and Services. UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in our health care programs. Contact UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services. UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Contact UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services’ Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Age
- Disability
- Sex (including sex stereotypes and gender identity)
Contact the OCR directly to file a complaint:

Director
U.S. Department of Health and Human Services’ Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (Voice)
800-537-7697 (TDD)
Complaint Portal – https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Religion
- Creed
- Sex
- Sexual Orientation
- Marital Status
- Public Assistance Status
- Disability

Contact the MDHR directly to file a complaint:
Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (Fax)
Info.MDHR@state.mn.us (Email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information
Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation’s outcome. You have a right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome period. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administration actions.

Contact DHS directly to file a discrimination complaint:

ATTN: Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

UCare Complaint Notice
You have the right to file a complaint with UCare if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Phone: 612-676-3200
1-800-203-7225 toll free

TTY: 612-676-6810 or
1-800-688-2534 toll free

Email: cag@ucare.org
Fax: 612-884-2021

Mailing address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052