REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

Address:
Medicare Pharmacy Prior
Authorization Department
P.O. Box 31397
Tampa, FL 33631-3397

Fax Number:
1-866-226-1093

You may also ask us for a coverage determination by phone at 1-855-565-9519, TTY: 711 or through our website at allwell.sunflowerhealthplan.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

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

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		
City	State	Zip Code
Phone		

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 believe 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 prescriber's 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:**

Supporting Information for an Exception Request or Prior Authorization

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 timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
Date Started: ☐ **NEW START**	Expected Length of Therapy:	Quantity per 30 days
Height/Weight:	Drug Allergies:	
DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. **(**If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)		**ICD-10 Code(s)**

Other RELEVANT DIAGNOSES:	**ICD-10 Code(s)**

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY

Any **FDA NOTED CONTRAINDICATIONS** to the requested drug? ☐ **YES** ☐ **NO**

Any concern for a **DRUG INTERACTION** with the addition of the requested drug to the enrollee's current drug regimen? ☐ **YES** ☐ **NO**

If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety

HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY

If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ **YES** ☐ **NO**

OPIOIDS – (please complete the following questions if the requested drug is an opioid)

What is the daily cumulative Morphine Equivalent Dose **(MED)**? _____ **mg/day**

Are you aware of other opioid prescribers for this enrollee? ☐ **YES** ☐ **NO**
If so, please explain.

Is the stated daily MED dose noted medically necessary? ☐ **YES** ☐ **NO**

Would a lower total daily MED dose be insufficient to control the enrollee's pain? ☐ **YES** ☐ **NO**

RATIONALE FOR REQUEST

☐**Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated.

☐**Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐**Medical need for different dosage form and/or higher dosage** Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists.

☐**Request for formulary tier exception** Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated.

☐**Other** (explain below)

Required Explanation _____
_____
_____
_____
_____
_____

Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

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

Allwell:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Allwell's Member Services telephone number listed for your state on the Member Services Telephone Numbers by State Chart. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Allwell 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 a grievance by calling the number in the chart below and telling them you need help filing a grievance; Allwell's Member Services is available to help you.

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, DC 20201, 1-800-368-1019 (TTY: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Member Services Telephone Numbers by State Chart

State	Telephone Number
Arizona	1-800-977-7522 (HMO and HMO SNP) (TTY: 711)
Arkansas	1-855-565-9518 (TTY: 711)
Florida	1-877-935-8022 (TTY: 711)
Georgia	1-844-890-2326 (HMO); 1-877-725-7748 (HMO SNP) (TTY: 711)
Indiana	1-855-766-1541 (HMO and PPO); 1-833-202-4704 (HMO SNP) (TTY: 711)
Kansas	1-855-565-9519 (HMO and PPO); 1-833-402-6707 (HMO SNP) (TTY: 711)
Louisiana	1-855-766-1572 (HMO); 1-833-541-0767 (HMO SNP) (TTY: 711)
Mississippi	1-844-786-7711 (HMO); 1-833-260-4124 (HMO SNP) (TTY: 711)
Missouri	1-855-766-1452 (HMO); 1-833-298-3361 (HMO SNP) (TTY: 711)
Nevada	1-833-854-4766 (HMO); 1-833-717-0806 (HMO SNP) (TTY:711)
New Mexico	1-833-543-0246 (HMO); 1-844-810-7965 (HMO SNP) (TTY: 711)
Ohio	1-855-766-1851 (HMO); 1-866-389-7690 (HMO SNP) (TTY: 711)
Pennsylvania	1-855-766-1456 (HMO); 1-866-330-9368 (HMO SNP) (TTY: 711)
South Carolina	1-855-766-1497 (TTY: 711)
Texas	1-844-796-6811 (H0062-001, 002, 003, 009; H5294-011, 012, 013, 014, 017, 018); 1-877-935-8023 (H5294-010, 015) (TTY: 711)
Wisconsin	1-877-935-8024 (TTY: 711)

Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the Member Services number listed for your state in the Member Services Telephone Number Chart.

SPANISH: ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al número del Departamento de Servicios al Afiliado que se enumera para su estado en la Ficha de Números de Teléfono del Departamento de Servicios al Afiliado.

CHINESE: 請注意：如果您使用中文，您可以免費獲得語言援助服務。請撥會員服務部電話號碼表所列的您所在州的會員服務部號碼。

VIETNAMESE: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số điện thoại phục vụ hội viên dành cho tiểu bang của quý vị trong Bảng số điện thoại dịch vụ hội viên.

FRENCH CREOLE (HAITIAN CREOLE): ATANSYON: Si w pale kreyòl ayisyen, ou ka resevwa sèvis gratis ki la pou ede w nan lang pa w. Rele nimewo sèvis manm pou eta kote w rete a. W ap jwenn li nan tablo nimewo telefòn sèvis manm yo.

KOREAN: 알림사항: 귀하가 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 받으실 수 있습니다. 가입자 서비스 전화번호 표에 있는 귀하의 주 가입자 서비스 안내번호로 전화하십시오.

FRENCH: ATTENTION : Si vous parlez français, un service d'aide linguistique vous est proposé gratuitement. Veuillez appeler le numéro de téléphone du Service aux membres spécifique à votre État qui se trouve dans le tableau de numéros de téléphone du Service aux membres.

ARABIC:

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية مُتاحة لك. اتصل برقم خدمات الأعضاء المُدرج في لائحة رقم هاتف خدمات الأعضاء الخاص بالولاية المقيم فيها.

POLISH: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług tłumaczeniowych. Zadzwoń pod numer działu obsługi klienta odpowiedni dla twojego stanu, dostępny w Wypisie numerów telefonu działu obsługi klienta.

RUSSIAN: ВНИМАНИЕ! Если Вы говорите на русском языке, мы можем предложить Вам бесплатные услуги переводчика. Позвоните в Отдел обслуживания участников по указанному для Вашего штата номеру в телефонном справочнике Отдела обслуживания участников

GERMAN: ACHTUNG: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie bitte die für Ihren Bundesstaat zuständige Rufnummer des Mitgliederkundendiensts an, die im Telefonverzeichnis des Mitgliederkundendiensts angegeben ist.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuha ka na mga libreng serbisyong pantulong sa wika. Tawagan ang numero ng Mga Serbisyo ng Miyembro na nakalista para sa iyong estado sa Tsart ng Numero ng mga Serbisyo ng Miyembro.

GUJARATI: સાવધાન: જો તમે ગુજરાતી બોલતા હો તો, ભાષા સહાય સેવાઓ, નઃશુલ્ક, તમારા માટે ઉપલબ્ધ છે. સભ્ય સેવા ટેલફ્રિન નંબર ચાર્ટમાં તમારા રાજ્ય માટે સૂચબિદ્ધ સભ્ય સેવાઓ નંબર પર કૉલ કરો.

PORTUGUESE: ATENÇÃO: Se falar português, estão disponíveis, gratuitamente, serviços de assistência linguística. Ligue para o número dos Serviços aos Membros indicado para o seu estado na Tabela de números de telefone destes serviços.

ITALIAN: ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Consulti la Tabella dei Numeri Telefonici dei Servizi per i Membri e chiami il numero dei Servizi per i Membri del Suo stato.

PENNSYLVANIAN DUTCH: Geb Acht: Wann du Deitsch schwetze kannscht, un Hilf in dei eegni Schprooch brauchst, kannscht du es Koschdefrei griege. Ruf die Glieder Nummer von dei Staat, ass iss uff die Lischt an die Glieder Hilf Telefon Nummer Kaart.

हिंदी (Hindi): भाषा सहायता सेवाएं, सहायक उपकरण और सेवाएं, और अन्य वैकल्पिक प्रारूप आपके लिए निःशुल्क उपलब्ध हैं। इन्हें प्राप्त करने के लिए, कृपया उपरोक्त नंबर पर कॉल करें।

Diné Bizaad (Navajo): Diné k'ehjí saad bee shíká a'doowoł nínízingo bee ná haz'ą, t'áá haada yit' éego kodóó naaltsoos da nich'į́ ál'į́įgo éí doodago t'áá ha'át'íhída Diné k'ehjí bee shíká a'doowoł nínízingo bee ná ahóót'i'. Á kót' éego shíká a'doowoł nínízingo hódahgo béésh bee hane'í biká'íjį' hodíílnih.

Ntawv Hmoob (Hmong): Muaj kev pab txhais lus, khoom pab mloog txhais lus thiab lwm yam kev pab pub dawb rau koj. Xav tau tej no, thov hu rau tus nab npawb saum toj saud.

ລາວ (Lao): ບໍລິການໃຫ້ຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍລິການ ແລະ ຄວາມຊ່ວຍເຫຼືອຕ່າງໆ, ແລະ ຮູບແບບທາງເລືອກອື່ນໆ ມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ຫາກຕ້ອງການຮັບເອົາ ກະລຸນາໂທ ເບີໂທທີ່ລະບຸໄວ້ຂ້າງເທິງ.

ျမန္မာ (Burmese) - ဘာသာစကားအကူအညီ ဝန္ေဆာင္မႈမ်ား၊ အရန္အေထာက္အပံ့မ်ားႏွင့္ ဝန္ေဆာင္မႈမ်ား၊ အျခားပုံစံမ်ားရွိ ေရြးခ်ယ္စရာမ်ားကို သင့္အခမဲ့ရရွိႏိုင္ပါသည္။ ၎င္းတို႔ကို ရယူရန္ အထက္ပါနံပါတ္ကို ဖုန္းဆက္ပါ။

(Shqip) (Albanian): Shërbimet e asistencës gjuhësore, ndihma dhe shërbimet shtesë plotësuese si dhe forma të tjera alternative ofrohen pa pagesë për ju. Për ta përfituar këtë, lutem merrni në telefon numrin e treguar më sipër.

Somali (Somali): Adeegyada caawinta luuqadaha, qalabka caawinta iyo adeegyo kale, iyo qaabab kale aya kuu diyaar ah si lacag la'aan ah. Si aad u hesho adeegyadan fadlan wac nambarka xaga sare ku xusan.