MEDICARE PART D
FORMULARY EXCEPTION INFORMATION

Please fax or mail the attached form to: **TOLL FREE** **Fax: 800-693-6703 Phone: 800-693-6651**	**Prime Therapeutics LLC** **Attn: Medicare Appeals Department** **2900 Ames Crossing Road** **Eagan, MN 55121**

Please read all instructions below before completing the attached form.

- Please complete the attached Request for Coverage of a Non-Formulary Drug (Formulary Exception Form)
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: **800-693-6703**. It is not necessary to fax this cover page.

Information about this Request for Coverage of a Non-Formulary Drug (Formulary Exception)

Use this form to request coverage of a drug that is not on the member's formulary.
*To view a list of the available formulary alternatives, visit www.myprime.com and search for the patient's appropriate Medicare health plan.

To process this request, documentation that all formulary alternatives have been previously tried, would not be as effective or would have adverse effects is required. Please provide clinical information or other evidence supporting the medical necessity of the non-formulary drug.

You can expedite this request by indicating its urgency at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously harm the member's life, health, or ability to regain maximum function.

MEDICARE PART D
FORMULARY EXCEPTION
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for Medicare Part D prospective, concurrent, and retrospective reviews.

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The following documentation is REQUIRED. For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary. To submit this form electronically, please click here or go to covermymeds.com.

Per CMS requirements – all standard requests are completed within 72 hours (including weekends)
If you request an expedited review, you certify that applying the 72-hour standard review time frame could seriously harm the patient's life, health or ability to regain maximum function. Please check the box to request an expedited review: ☐

PATIENT, INSURANCE and PRESCRIBER/CLINIC INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:		Patient Telephone Number:	
Prescriber Name:	Prescriber NPI#:	Specialty:	Clinic Contact Person's Name:
Clinic Name:		Clinic Address:	
City, State, Zip:	Clinic Phone #:	Clinic Secure Fax #:	
Is the patient a long term care facility resident? ☐ Yes ☐ No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:	LTC Phone #:	LTC Secure Fax #:	
Medication Requested:		Strength:	
Dosing Schedule:		Quantity per Month:	

Please list **ALL** diagnoses associated with use of medication. *To be eligible for coverage, drug must be prescribed for a medically accepted indication as defined by Medicare law.

Diagnosis – ICD code plus description: _____
Diagnosis – ICD code plus description: _____
Diagnosis – ICD code plus description: _____

Is the patient currently treated with the requested medication (i.e., this request is for a refill)? ..... ☐ Yes ☐ No

If yes, when was treatment with the requested medication started? _____

List **ALL** previously attempted drugs and indicate any adverse effects requiring discontinuation. Please provide dates of use.

1._____ 2._____ 3._____ 4. _____

If no available formulary alternatives have been previously tried, please check this box: ☐

Medical Justification: Please provide medical justification for the non-formulary drug exception request. Please address why ALL formulary alternatives on any tier of the formulary for treatment of the same condition not yet attempted would not be as effective or would cause adverse effects.

If the patient is stable on requested drug, is there high risk of adverse clinical outcome with medication change to available alternative(s)? If yes, specify anticipated adverse event in relation to patient condition(s) and/or available alternative(s):_____

_____
_____
_____
_____

* For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary.

I attest that the information provided on this form is true and accurate as of this date:

Prescriber's signature: _____ **Date**: _____