

Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- **Biotech or other specialty drugs for which drug-specific forms are required. Go to www.arbcb.com.**

Patient Information				Prescriber Information			
Patient Name:				Prescriber Name:			
Member ID#:				NPI# (if available):			
Address:				Address:			
City:		State:		City:		State:	
Home Phone:		Zip:		Office Phone #:		Office fax #:	
Sex (circle): M F		DOB:		Contact Person:			
Diagnosis and Medical Information							
Medication:			Strength and Route of Administration:			Frequency:	
<input type="checkbox"/> New Therapy OR Date Therapy Initiated:			Expected Length of Therapy:			Qty:	
Height/Weight:		Drug Allergies:		Diagnosis:			
Prescriber's Signature:						Date:	
Rationale for Exception request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION							
<input type="checkbox"/> 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);							
<input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change ➔ Specify below: Anticipated significant adverse clinical outcome							
<input type="checkbox"/> 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							
<input type="checkbox"/> 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							
<input type="checkbox"/> Other: _____ ➔ Explain below							
REQUIRED EXPLANATION: _____ _____ _____							
Request for Expedited Review							
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] ➔ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIMEFRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.							