

**REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION**

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

Address:  
CVS/Caremark  
P.O. Box 52000  
MC109  
Phoenix, AZ 85072-2000

Fax Number: 1-855-633-7673

You may also ask us for a coverage determination by phone at 866-443-0935 or 711 for TTY or through our website at [www.elderplanfida.org](http://www.elderplanfida.org).

**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).\*
- 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 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*):

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**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).**

<b>Signature of person requesting the coverage determination (the enrollee, or the enrollee’s prescriber or representative):</b>	<b>Date:</b> _____
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**Supporting Information for an Exception Request or Prior Authorization**

**FORMULARY 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.**

<b>Prescriber's Information</b>			
Name _____			
Address _____			
City _____	State _____	Zip Code _____	
Office Phone _____	Fax _____		
Prescriber's Signature _____			Date _____

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:

Rationale for Request
<input type="checkbox"/> <b>Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure</b> [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"/> <b>Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change</b> [Specify below: Anticipated significant adverse clinical outcome] <input type="checkbox"/> <b>Medical need for different dosage form and/or higher dosage</b> [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason] <input type="checkbox"/> <b>Other</b> (explain below) <b>Required Explanation:</b> _____ _____ _____ _____ _____

**Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.**

Elderplan FIDA Total Care is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Participant Handbook.

Limitations and restrictions may apply. For more information, call Elderplan FIDA Total Care Participant

Services or read the Elderplan FIDA Total Care Participant Handbook. This means that you need to follow certain rules to have Elderplan FIDA Total Care pay for your services.

Benefits, List of Covered Drugs, and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year.

You can get this information for free in other languages. Call 1-855-462-3167 and TTY users call 711 during 8am to 8pm seven days a week. The call is free.

Puede obtener esta información de manera gratuita en otros idiomas. Llame al 1-855-462-3167 y TTY/TDD 7-1-1 de lunes a domingos de 8:00 am a 8:00 pm. La llamada es gratuita.

Ou ka jwenn enfòmasyon sa a gratis nan lòt lang. Rele nan 1-855-462-3167 ak nan TTY/TDD (pou moun ki gen pwoblèm tande oswa moun ki bèbè) 7-1-1 de lendi a dimanch 8:00 am - 8:00 pm. Apèl la gratis.

이 정보는 다른 언어로도 제공됩니다(무료). 월요일-일요일 8:00 am - 8:00 pm 중 1-855-462-3167 나 TTY/TDD 7-1-1 로 전화하십시오. 통화료는 무료입니다.

您可免費取得以其他語言撰寫的資訊。請於週一至週日上午8時至下午8時致電 1-855-462-3167, TTY/TDD 使用者：7-1-1。此為免付費電話。

Данная информация доступна бесплатно на других языках. Звоните по номеру 1-855-462-3167 или 7-1-1 (линия TTY/TDD) с понедельника по воскресенье с 8:00 до 20:00. Звонок бесплатный.

È possibile ricevere queste informazioni in altre lingue gratuitamente. Contatta il 855-462-3167 e TTY/TDD 7-1-1 dal lunedì alla domenica dalle ore 8:00 alle ore 20:00. Il servizio è gratuito.

You can ask for this handbook in other formats such as large print. Call 1-855-462-3167, 8 a.m. to 8 p.m., 7 days a week (TTY users should call 711).

The State of New York has created a Participant Ombudsman Program to provide Participants free, confidential assistance on any services offered by Elderplan FIDA Total Care. The Participant Ombudsman may be reached toll-free at 1-844-614-8800 or online at [www.icannys.org](http://www.icannys.org).

**ATTENTION:** If you speak a non-English language or require assistance in ASL, language assistance services, free of charge, are available to you. Call 1-855-462-3167 (TTY: 711).

(Spanish) **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-462-3167 (TTY: 711).

(Chinese) **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 1-855-462-3167 (TTY: 711)。

(Russian) **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-462-3167 (телетайп: 711).

(French Creole) **ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-462-3167 (TTY: 711).

(Korean) **주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-462-3167 (TTY: 711)번으로 전화해 주십시오.

(Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-462-3167 (TTY: 711).

(Yiddish) אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט  
1-855-462-3167 (TTY: 711)

(Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-462-3167 (TTY: 711)।

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-462-3167 (TTY: 711).

(Arabic) ملحوظة: إذا كنت تتحدث لغة غير الإنجليزية أو تحتاج إلى مساعدة في ASL، فإن خدمات المساعدة اللغوية تتوافر لك مجاناً.  
اتصل برقم (1-855-462-3167 (TTY: 711)

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-462-3167 (ATS: 711).

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں  
1-855-462-3167 (TTY: 711)

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-462-3167 (TTY: 711).

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-462-3167 (TTY: 711).

(Albanian) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-462-3167 (TTY: 711).