REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

Address:
Envision Pharmaceutical Services, LLC
ATTN: Clinical-Coverage Determination Request
2181 East Aurora Road
Suite 201
Twinsburg, Ohio 44087

Fax Number:
1-877-503-7231

You may also ask us for a coverage determination through our website at www.medicare.virginiapremier.com or by phone at 1-844-838-0705, TTY users should call 711. Live representatives are available from 24 hours, 7 days a week.

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 co-payment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower co-payment (tiering exception).*

☐ I have been using a drug that was previously included on a lower co-payment tier, but is being moved to or was moved to a higher co-payment tier (tiering exception).*****

☐ My drug plan charged me a higher co-payment 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)*:

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_____

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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).**

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:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

Rationale for Request

☐ **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)]

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]

☐ **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]

☐ **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]

☐ **Other** (explain below)
Required Explanation _____
_____
_____
_____
_____

Virginia Premier Health Plan Inc. is an HMO and HMO SNP organization with a Medicare contract. Enrollment in any Virginia Premier Health Plan Inc. plan depends on contract renewal.

Notice of Non-Discrimination
Virginia Premier Health Plan, Inc. (Virginia Premier) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Virginia Premier does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Virginia Premier:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - 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
    - Information written in other languages

If you need these services, contact Member Services at 1-877-739-1370, TTY: 711.

If you believe that Virginia Premier 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 with:

Virginia Premier
Attn: Grievances & Appeals Manager
P.O. Box 5244
Richmond, VA 23220
1-877-739-1370, TTY: 711
Fax: 800-289-4970
grievancesandappeals@vapremier.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Grievances & Appeals Manager 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

Multi-Language Insert
Multi-Language Interpreter Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-739-1370 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-739-1370 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-877-739-1370 (TTY: 711) 번으로 전화해주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Xin gọi số 1-877-739-1370 (TTY: 711).

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 1-877-739-1370
(TTY: 711)。

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-739-1370
(الهاتف النصي (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may mga magagamit kang libreng serbisyo ng tulong sa wika. Tumawag sa 1-877-739-1370 (TTY: 711).

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره
1-877-739-1370 (TTY: 711) تماس بگیرید.

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-877-739-1370 (መስማት ለተሳናቸው: 711).

توجہ دیں: اگر آپ اردو بولتے ہیں تو، زبان سے متعلق اعانت کی خدمات، آپ کے لیے مفت دستیاب ہے۔
1-877-739-1370 (TTY: 711) پر کال کریں۔

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-739-1370 (ATS: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-739-1370 (линия TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-877-739-1370 (TTY: 711) पर कॉल करें।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-739-1370 (TTY: 711).

মনোযোগ দিনঃ আপনি যদি বাংলাতে কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-877-739-1370 (TTY: 711) ।

YI LE: I balè u pot tila hop won ngim bod i kobol mahop i la hola wè ni hop won, u saa béé to yom. Sébél 1-877-739-1370 (TTY: 711).

GENU NTI: Ọ buru na ina asu asusu Igbo, enyemaka na-ahazi asusu, bu n’efu, diri gi mgbe niile. Kpoo nomba ndi a 1-877-739-1370 (TTY: 711).

AKIYESI: Bi o ba nsọ èdè Yorùbá, ọfé ni iranlọwọ lori èdè wa fun yin. Ẹ pe ẹrọ-ibanisọrọ yi 1-877-739-1370 (TTY: 711).