

REQUEST FOR MEDICARE DRUG COVERAGE DETERMINATION

Use this form to ask our plan for a coverage determination. You can also ask for a coverage determination by phone at (833) 201-6413 or through our website at www.healthy-ms.com. You, your doctor or prescriber, or your authorized representative can make this request.

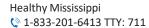
Plan Enrollee	
Name	Date of birth
Street address	City
State	ZIP
Phone	Member ID #
If the person making this reque	est isn't the plan enrollee or prescriber:
Relationship to plan enrollee	
Street address (include City, Sta	ate and ZIP)
Phone	
enrollee (a completed Au equivalent). For more info	th this form showing your authority to represent the thorization of Representation Form CMS-1696 or ormation on appointing a representative, contact our EARE. (1-800-633-4227). TTY users can call 1-877-486-
Name of drug this request is a available)	about (include dosage and quantity information if
	Type of Request
☐ My drug plan charged me a hi	gher copayment for a drug than it should have
☐ I want to be reimbursed for a	covered drug I already paid for out of pocket
☐ I'm asking for prior authorization	on for a prescribed drug (this request may require
supporting information)	www.healthy-ms.com



Signature:	Date:
☐ YES, I need a decision within 24 hours. If you have a syour prescriber, attach it to this request.	upporting statement from
Do you need an expedited dealing of the seriously harm your life, health, or ability to regain maximum expedited (fast) decision. If your prescriber indicates that was seriously harm your health, we'll automatically give you a decident get your prescriber's support for an expedited request, we requires a fast decision. (You can't ask for an expedited decipay you back for a drug you already received.)	andard decision could function, you can ask for an iting 72 hours could ision within 24 hours. If you ve'll decide if your case
Additional information we should consider (submit any support form):	rting documents with this
☐ I've been using a drug that was on a lower copayment tier moved to a higher copayment tier (tiering exception)	before, but has or will be
☐ My drug plan charges a higher copayment for a prescribed another drug that treats my condition, and I want to pay the locopayment (tiering exception)	
$\hfill\Box$ I'm asking for an exception to the plan's limit on the number can get so that I can get the number of pills prescribed to me	
$\hfill\Box$ I'm asking for an exception to the requirement that I try and prescribed drug (formulary exception)	other drug before I get a
$\hfill\Box$ I've been using a drug that was on the plan's list of covere been or will be removed during the plan year (formulary exce	
$\Box \hspace{0.5mm} \textbf{I}$ need a drug that's not on the plan's list of covered drugs (formulary exception)
For the types of requests listed below, your prescriber M supporting the request. Your prescriber can complete page "Supporting Information for an Exception Request or Prior Au	s 3 and 4 of this form,

How to submit this form

Submit this form and any supporting information by mail or fax:



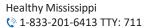


Address: Capital Rx Attention Prior Authorization 9450 SW Gemini Dr., #87234 Beaverton, OR 97008 Fax Number: 833-434-0563

Supporting Information for an Exception Request or Prior Authorization To be completed by the prescriber

☐ REQUEST FOR EXPEDITED I certify that applying the 72 hou jeopardize the life or health of the maximum function.	r standard re	eview timeframe may seriou	sly	w,
Prescriber Information				
Name				
Street Address (Include City, Stat	e and ZIP)			
Office phone				
Fax				
Signature		Date		
Diagnosis and Medical Information				
Medication:	Strength an	d route of administration:		
frequency:	Date started			
Expected length of therapy:	Quantity pe	r 30 days:		
Height/Weight:	Drug allergi	es:		
DIAGNOSIS – Please list all dia drug and corresponding ICD-10 (If the condition being treated with the requestreath, chest pain, nausea, etc., provide the	codes sted drug is a sym diagnosis causing	otom e.g. anorexia, weight loss, shortne	ess of	9-10 Code(s)
Other RELAVENT DIAGNOSES:			ICD	9-10 Code(s)

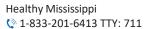
DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)





DRUGS TRIED if quantity limit is an issue, list unit dose/total daily dose tried)	DATES of Drug Trials	RESULTS of prev FAILURE vs INTO		
What is the enrollee's current drug	regimen for the condition(s	s) requiring the reques	sted drug?	
DRUG SAFETY				
Any FDA NOTED CONTRAINDICA				NO
Any concern for a DRUG INTERAC	CTION when adding the re	quested drug to the er		•
regimen? If the answer to either of the questi		<u>, , , , , , , , , , , , , , , , , , , </u>		NO
potential risks despite the noted co				
HIGH RISK MANAGEMENT OF	DRUGS IN THE ELDE	RLY		
If the enrollee is over the age of 65	_	fits of treatment with t	•	•
outweigh the potential risks in this			☐ YES	
OPIOIDS - (answer these 4 quest				
What is the daily cumulative Mo	<u> </u>	(IVIED) ?		ng/da
Are you aware of other opioid present if so, please explain.	cribers for this enrollee?		☐ YES	
Is the stated daily MED dose noted	I medically necessary?		□ YES	□N
Would a lower total daily MED dose	e be insufficient to control	the enrollee's pain?	☐ YES	\square N
ATIONALE FOR REQUEST				
☐ Alternate drug(s) contraind outcome, e.g. toxicity, allergy, HISTORY section, specify below: (outcome, list drug(s) and adverse dose and length of therapy for drug preferred drug(s)/other formulary d	, or therapeutic failure 1) Drug(s) tried and results butcome for each, (3) if the g(s) trialed, (4) if contraind	[If not noted in the DRs of drug trial(s) (2) if a rapeutic failure, list mication(s), list specific	UG dverse aximum	
☐ Patient is stable on current outcome with medication charadverse clinical outcome and why to condition has been difficult to controudition), the patient had a signific previously (e.g. hospitalization or frosignificant limitation of functional st	nge A specific explanation this outcome would be exploid (many drugs tried, multicant adverse outcome whe requent acute medical visit	of any anticipated signetted is required – e.gole drugs required to on the condition was not be the condition was not bea	nificant g. the control ot controlled	
significant illification of functional sc	alus, undue pain and sune	ing),etc.		

Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s), (2) explain medical reason





specify below: (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 equested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]	specify below: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if advers outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are	(3) include why less free strength exists]	uent dosing \	with a higher s	trength is not an o	option – if a higl	her
Other (explain below)	Other (explain below)	specify below: (1) formu outcome, list drug(s) and requested drug, list max	ary or preferi d adverse out imum dose a	red drug(s) trie come for each nd length of th	ed and results of one of (3) if therapeution erapy for drug(s)	lrug trial(s) (2) i c failure/not as o trialed, (4) if	f advers effective
		☐ Other (explain belo	w)				