MedImpact

Medicare Part D Coverage Determination Request Form

This form is being used for:
Check one: ☐ Initial Request   ☐ Continuation of Therapy/Renewal Request
Reason for request *(check all that apply)*: ☐ Prior Authorization ☐ Formulary Exception ☐ Quantity Exception ☐ Compound Formulary Exception ☐ Copay Tier Exception ☐ Other *(please specify)*: _____

Patient Information
Patient Name: DOB:
Drug Allergies :   Height/Weight: Gender: ☐ Male ☐ Female
Address: City: State: Zip:
Member ID #:   Plan Name:

Prescriber Information
Prescribing Clinician: Office Phone #:
Specialty: Office Secure Fax #:
NPI #:   DEA/xDEA:
Address: City: State: Zip:
Contact Person (if different than provider):
Prescriber's or Authorized Representative Signature: **Date:**

Medication Information
Medication Being Requested:
Strength: Quantity: Directions:
Diagnosis related to this request:
ICD Code(s):
If applicable, does the prescriber acknowledge or is aware that The American Geriatrics Society (AGS) considers the requested medication to be of high risk for patients 65 years old or older? ☐ Yes ☐ No
Is the patient currently enrolled in HOSPICE? ☐ Yes ☐ No

Previous Therapies Tried and/or Failed			
Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Failure

Additional information related to this request (lab values, non-pharmacologic therapies, contraindications, explanations for exceptions, etc):

☐ **By checking this box, I attest this is an *urgent case*, meaning that an expedited determination is necessary to prevent serious threat to life, limb, or eyesight; or threatens the body's ability to regain maximum function; or is needed to manage severe pain.**