

Coverage Determination Form

Date of Request: _____

Fax Form to 1-866-481-3704

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs or prescription vitamins (except prenatal vitamins and fluoride preparations).

Enrollee Information:

Member Name: _____

Enrollment / Cardholder ID: _____

Member Telephone #: _____

Group Name / Group#: _____

Birth Date: _____ Age: _____ Male Female

Address: _____

City, State, Zip: _____

Prescribing Physician Information:

Name: _____

Specialty: _____

Address: _____

City State Zip: _____

Phone: () _____ Fax: () _____

Name of Prescription Drug you are requesting:
Strength/ Dose:
Condition/Diagnosis – Physician Statement (Please include alternative Rx's that have been tried.):

Coverage Determination Form

Contact Pharmacy? **Y** **N** Pharmacy Phone #: _____

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 an exception to the requirement that I try another drug before I get the drug my doctor 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 doctor prescribed (formulary exception).
- I want to be reimbursed for a covered prescription drug that I paid for out-of-pocket.
- 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).
 - I am requesting a tiering exception: (lower copay for a formulary drug) Cannot be requested for non formulary or Prior authorization drugs)
Please submit statement of need or financial limitations.

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

- I need an expedited coverage determination (attach physician's supporting statement, if applicable)

Beneficiary/Requestor's Signature

Date

Fax this form to Sterling Retiree Rx at 1-866-481-3704.

Contact the Customer Care Center toll-free at # 1-800-313-7667.

For office use only.

Date Received: _____

Reviewed By: _____

Forwarded To: _____