

# Request for Prescription Information or Change

Medicare Prescription Drug Coverage  
Provider Communication Form

TO: (Prescribing Physician): \_\_\_\_\_ Date: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Name of Drug Plan: \_\_\_\_\_ Plan Phone (if available): \_\_\_\_\_

Member Number: \_\_\_\_\_ Prescription Number : \_\_\_\_\_

## PRESCRIPTION ISSUES

The patient's drug plan has indicated that it will not pay for \_\_\_\_\_  
\_\_\_\_\_ for this patient because:

- Prior authorization required
- Step therapy required. Plan will pay for \_\_\_\_\_
- Plan only authorizes \_\_\_\_\_ dosage units (tablets/capsules) per prescription
- Plan does not pay for drug in dosage/format prescribed
- Drug is not on the formulary. NOTE:
  - Plan authorized one-time only payment for this drug
  - Plan did not authorize one-time payment
  - Other drugs on the formulary include (if available): \_\_\_\_\_

Other reason(s) \_\_\_\_\_

The patient's drug plan covers this drug, but with a higher tiered co-pay. Preferred drugs available at lower co-pay (if available): \_\_\_\_\_

**ACTION REQUESTED – Please Respond To Pharmacy:**

Pharmacist Requesting Action: \_\_\_\_\_

- Urgent - patient is waiting**
- By next refill: \_\_\_\_\_ (Date)
- Provide alternative medication: \_\_\_\_\_
- Other recommended action: \_\_\_\_\_

**For Fax Back:**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACTION REQUESTED – Contact Drug Plan to Request**  prior authorization  formulary exception

**INFORMATION ONLY - No Immediate Action Necessary**

PLEASE NOTE: Medicare Part D does not pay for 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).

FROM: Pharmacy Name: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Address: \_\_\_\_\_

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

Use of this form is endorsed by the Alzheimer's Association, American Medical Association, American Pharmacists Association, Center for Medicare Advocacy, Medical Group Management Association, National Community Pharmacists Association and the National Council on the Aging

The Centers for Medicare & Medicaid Services has reviewed this fax form, but does not require its use. Use of the form for communications between pharmacists and physicians is voluntary. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.