

# TexanPlus<sup>®</sup> HMO/HMO-POS

Medicare Advantage Health Plans

## REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to TexanPlus<sup>®</sup> HMO or TexanPlus<sup>®</sup> HMO-POS by mail or fax:

Address: P.O. Box 52000  
Phoenix, AZ 85072-2000

Fax Number:  
1-855-633-7673

You may also ask us for a coverage determination by phone at 1-855-344-0930 or through our website at [www.TexanPlus.com](http://www.TexanPlus.com) or [www.TexanPlusPOS.com](http://www.TexanPlusPOS.com).

**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 copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).\*
- I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).\*
- My drug plan charged me a higher copayment 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*):

**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 of person requesting the coverage determination (the enrollee, or the enrollee’s prescriber or representative):**

\_\_\_\_\_ **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.

<b>Prescriber's Information</b>	
Name _____	
Address _____	
City _____	State _____ Zip Code _____
Office Phone _____	Fax _____
<b>Prescriber's Signature</b> _____	<b>Date</b> _____

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
<input type="checkbox"/> <b>Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure</b> Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s) <input type="checkbox"/> <b>Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change</b> Specify below: Anticipated significant adverse clinical outcome <input type="checkbox"/> <b>Medical need for different dosage form and/or higher dosage</b> Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason <input type="checkbox"/> <b>Request for formulary tier exception</b> 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 <input type="checkbox"/> <b>Other</b> (explain below) <b>Required Explanation:</b> _____ _____ _____ _____

TexanPlus® HMO and TexanPlus® HMO-POS are Medicare Advantage plans with a Medicare contract. Enrollment in these plans depends on contract renewal. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. TexanPlus® HMO and TexanPlus® HMO-POS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (TTY: 711). **Chinese:** 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 1-888-736-7442 (TTY: 711)。