



# REQUEST FOR MEDICARE ADVANTAGE PRESCRIPTION DRUG COVERAGE DETERMINATION

Enrollee's Name

Enrollee's Date of Birth

Enrollee's Medicare Number

Enrollee's Part D Plan ID Number

Requestor's Name (if not enrollee)

Requestor's relationship to Enrollee (attach a completed *Medicare Part D Appointment of Representative* form or equivalent documentation that shows authority to represent enrollee, if other than prescribing physician. You can obtain a copy of the *Medicare Part D Appointment of Representative* form at the *For Seniors* section of our website at [www.bluecrossma.com](http://www.bluecrossma.com))

Enrollee/Requestor's Address

City

State

Zip Code

( )  
Phone

**Name of prescription drug you are requesting** (if known, include strength, quantity and quantity requested per month):

## Prescribing Physician's Information

Name

Address

City

State

Zip Code

( )  
Work Phone

( )  
Fax

## 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).\*
- The drug that my doctor has prescribed requires prior authorization.
- I am requesting an exception to the prior authorization requirements for the drug that my doctor has prescribed
- 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).\*
- A higher copayment is charged for the drug my doctor prescribed than is charged 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).\*
- I want to be reimbursed for a covered prescription drug that I paid for out-of-pocket.

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**\*NOTE: If you are asking for a formulary exception, tiering exception or an exception from prior authorization requirements, your prescribing physician must provide a statement to support your request. Please note that you cannot obtain a brand name drug at the copayment that applies to generic drugs.**

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Additional comments or information we should consider (*attach any supporting documents*):

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If you 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 has supplied you with supporting documentation for an expedited review, please include that information when sending this form to us. If you haven't obtained your physician's documentation or support, we will decide if your health condition requires an expedited decision.

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

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Beneficiary's/Requestor's Signature

Date

Please send this completed form to: Medicare Advantage Part D Coverage Determinations  
Blue Cross and Blue Shield of Massachusetts  
P.O. Box 9201  
N. Quincy, MA 02171-9201

Or by FAX to: 617-246-8506