

## request for medicare prescription drug coverage determination/exception form

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).

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### Member's information

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medicare number: \_\_\_\_\_ Fallon Senior Plan ID number: \_\_\_\_\_

Authorized representative's name (if applicable): \_\_\_\_\_

If you are the authorized representative (and not the prescribing provider), you must provide the following information:

Your relationship to the member: \_\_\_\_\_

Your address: \_\_\_\_\_

City/town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Your phone number: \_\_\_\_\_

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

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### Prescribing provider's information

Name: \_\_\_\_\_ Medical specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City/town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Office phone number: \_\_\_\_\_ Office fax number: \_\_\_\_\_

Office contact person (other than provider): \_\_\_\_\_

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### Type of coverage determination/exception 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 provider prescribed (formulary exception).\*
- I request prior authorization for the drug that my provider has prescribed.
- I request an exception to the plan's limit on the medication (quantity limit) I can receive so that I can get the amount of medication my provider prescribed (formulary exception).\*
- My drug plan charges a higher copayment for the drug that my provider prescribed than for another drug that treats my condition, and I want to pay the lower copayment (tiering/category exception).\*
- I have been using a drug that was previously included on a lower copayment tier/category, but is being moved to or was moved to a higher copayment tier/category (tiering/category 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 or tiering/category exception, your PRESCRIBING PROVIDER must provide a statement to support your request. In addition, you cannot obtain a brand-name drug at the copayment that applies to generic drugs.**

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

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If you, or your prescribing provider, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life, health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing provider 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, health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your provider's support, we will decide if your health condition requires a fast decision.

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

\_\_\_\_\_  
Member's/authorized representative's signature

\_\_\_\_\_  
Date

**Send this request to:**  
Fallon Community Health Plan  
Attn: Pharmacy Services  
10 Chestnut St.  
Worcester, MA 01608

**Fax this request to:**  
Fallon Community Health Plan  
Attn: Pharmacy Services  
Fax number: 1-508-791-5101

**Note that FCHP may require additional information to process your request. Please refer to your *Member Handbook/Evidence of Coverage* for more information.**



fallon senior plan™