REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:	Fax Number:
Medicare Part D Prior Authorizations PO Box 419069 Rancho Cordova, CA 95741-9069	1-800-977-8226

You may also ask us for a coverage determination by phone at 1-800-977-7522 (Allwell Dual Medicare (HMO SNP) members call 1-877-935-8020), TTY: 711, 8:00 a.m. - 8:00 p.m., 7 days a week or through our website at https://allwell.healthnetadvantage.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)*:

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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:	**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.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

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			

☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** Specify below: Anticipated significant adverse clinical outcome

☐ **Medical need for different dosage form and/or higher dosage** Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

☐ **Request for formulary tier exception** 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

☐ **Other** (explain below)

Required Explanation _____

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Allwell has a contract with Medicare to offer HMO, PPO and HMO SNP plans. Allwell has a contract with Medicare and the state Medicaid program to offer HMO SNP coordinated care plans. Enrollment in an Allwell plan depends on contract renewal.

Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

Allwell complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Allwell does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Allwell:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Allwell's Member Services at: 1-800-977-7522 (HMO and HMO SNP) (TTY: 711). From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Allwell has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Allwell's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

SPANISH	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
NAVAJO	SHOO KWE'É: Diné bizaad bee yáníłti'go, saad bee 'áka'e'eyeed bee 'áka'anída'awo', t'áá jíík'eh, nihá hóló̧. kohjį' biniiyá holne' dooleeł 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
CHINESE	注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).。
VIETNAMESE	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
ARABIC	تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم. 1-800-977-7522 (HMO and HMO SNP) (رقم هاتف الصم والبكم: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (HMO and HMO SNP) (TTY: 711) 번으로 전화해 주십시오.
FRENCH	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
GERMAN	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
RUSSIAN	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
JAPANESE	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-977-7522 (HMO and HMO SNP) (TTY: 711) まで、お電話にてご連絡ください。
PERSIAN	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-977-7522 (HMO and HMO SNP) (TTY: 711) تماس بگیرید.
SYRIAC	ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܡܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܦܠܚܬ ܠܚܕܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
SERBOCROATIAN	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
THAI	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).