Health Net®

MEDICARE & MEDICARE-MEDICAID DRUG COVERAGE DECISION REQUEST

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

Address:
Health Net Community Solutions, Inc.
Attn: Prior Authorization
PO Box 419069
Rancho Cordova, CA 95741-9069

Fax Number:
1-800-977-8226

You may also ask us for a coverage decision by phone at 1-855-464-3571 (for Los Angeles County), 1-855-464-3572, (for San Diego County), TTY: 711, 24 hours a day, 7 days a week or through our website at www.healthnet.com.

Who May Make a Request: Your doctor or other provider can ask for a coverage decision on your behalf. You can name another person to act as your "representative" to ask for a coverage decision. If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696. The form will give the person permission to act for you. You must give us a copy of the signed form.

Member Information

Member Name _____ Date of Birth _____

Address _____

City _____ State_____ Zip Code _____

Phone _____ Member ID # _____

Complete the section below ONLY if you are not the member or prescriber:

Requestor's Name _____

Relationship to Member _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

For requests made by someone other than the member or the prescriber:
Attach proof that you can represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact Member Services or 1-800-Medicare.

Material ID # Y0035_2014_0542 (H0351, H0562, H5439, H5520, H6815, EG) CMS Accepted 02172014
H3237_2014_0542 CMS Accepted 02232014

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

Type of Request

- ☐ I need a drug that is not on the Drug List (formulary exception).*
- ☐ I have been using a drug that was on the Drug List, but is being removed or was removed during the plan year (formulary exception).*
- ☐ I need prior approval for a drug.*
- ☐ I need an exception to the requirement that I try another drug before I get the drug prescribed for me (formulary exception).*
- ☐ I need an exception to the plan's limit on the number of pills (quantity limit) I can get (formulary exception).*
- ☐ My plan charges a higher copay for this drug than it charges for another drug that treats my condition. I want to pay the lower copay. (tiering exception).*
- ☐ I am using a drug that is being moved to or was moved to a higher copay tier (tiering exception).*

***NOTE: Your prescriber MUST provide a statement supporting your request for a formulary or tiering exception. Prior approval or other coverage requests may require a supporting statement. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization".**

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

Important Note: Fast Decisions

Medi-Cal coverage requests are processed within 24 hours or 1 business day.

Standard requests for Part D drugs are processed within 72 hours. Urgent (fast) requests for Part D drugs are processed within 24 hours.

If you or your prescriber think your health may be harmed if you have to wait 72 hours for a decision, you can ask for a fast exception. If your prescriber supports your request, we will give you a decision within 24 hours of receiving your prescriber's supporting statement. You cannot ask for a fast decision if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU THINK YOU NEED A DECISION WITHIN 24 HOURS (attach your prescriber's supporting statement to this request).**

Signature of person requesting the coverage decision (the member, or the prescriber or representative):

_____

Date:

For Providers Only: 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 for a Medicare Part D drug may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Note: Requests for Medi-Cal covered drugs are processed within 24 hours or 1 business day**

Prescriber 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:_____
_____
_____
_____
_____
_____

Health Net Community Solutions, Inc. is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

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

Health Net Cal MediConnect:
• 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 Health Net Cal MediConnect's Customer Contact Center at Los Angeles County: 1-855-464-3571/San Diego County: 1-855-464-3572 (TTY: 711), Monday through Friday, 8:00 a.m. to 8:00 p.m. At other times – including Saturday, Sunday and federal holidays – you can leave a voicemail. We will return your call the following business day. The call is free.

If you believe that Health Net Cal MediConnect 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; Health Net Cal MediConnect's Customer Contact Center 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.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).
Chinese Mandarin:

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 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

Chinese Cantonese:

注意：如果您說英文，您可獲得免費的語言協助服務。請致電 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego)（聽障專線：711）。

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

French:

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (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 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).
번으로 전화해 주십시오.

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (телетайп: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية لك توافرت. بالمجان اتصل برقم 1-855-464-3571 (Los Angeles) والبكم الصم هاتف رقم: 711.

Hindi:

ध्यान दें: यदद आप बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711). पर कॉल करें।.

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

Portugués:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

French Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (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。1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711). まで、お電話にてご連絡ください。

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با 1-855-464-3572 (San Diego), 1-855-464-3571 (Los Angeles) (TTY: 711) تماس بگیرید.

Armenian:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY (հեռատիպ)՝ 711):

Cambodian:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ
1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).

Hmong:
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.
Hu rau 1-855-464-3571 (Los Angeles), 1-855-464-3572 (San Diego) (TTY: 711).