Fresenius Health Partners
PPO SNP
Accountable Kidney Care

PRESCRIBER REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

Formulary and Criteria may be reviewed on our website
www.fmchp.com

Please complete ALL FIELDS and fax this form to the Fresenius Health Partners' Pharmacy Department at (615) 782-7869. For assistance, you may contact us at 1-866-715-7519, 7am – 8pm Central time, Monday through Friday. Coverage Determination criteria is available upon request. This form cannot be used to request Medicare excluded drugs such as barbiturates, benzodiazepines, fertility, weight loss or gain, hair growth, or prescription vitamins (except for prenatal/fluoride).

***REQUIRED FIELDS – USE BLACK INK (One Medication per Form)**

*Patient Name		*Medication, Strength and Route of Administration:	
*Windsor or Windsor-Sterling ID # (On Front of ID Card):		*Quantity and Frequency:	
*Patient Height/Weight/BMI:	*Date of Birth:	*Expected Length of Therapy ***(Max is 1 yr)***	*Drug Allergies:
*Physician FULL Name / Specialty:		*Diagnosis or ICD-9:	
*Contact Name in MD Office:		Has member been on medication in the past? ❑Yes ❑No If yes, for how long?	
*Office Phone:	Office Fax:	If injectable, is patient self-administering drug? ❑Yes ❑No If no, who will administer drug?	
*Pharmacy Name & Phone:		IF TRANSPLANT DRUG: Was the transplant covered by Medicare Part A? ❑ Yes ❑ No *If yes, give date:*	

Type of Coverage Determination Request

- ☐ My patient needs a prior authorization for a drug on Fresenius Health Partners' formulary (Prior Authorization).
- ☐ My patient needs a drug that is not on the plan's list of covered drugs (Non-Formulary Exception).*
- ☐ My patient was taking 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 (Non-Formulary Exception).*
- ☐ As the prescriber, I am requesting an exception to the requirement that my patient try another drug before obtaining the drug I am prescribing (Step Therapy Formulary Exception).*
- ☐ As the prescriber, I am requesting an exception to the plan's limit on the number of pills (quantity limit) that my patient can receive for the medication I am prescribing (Quantity Limit Formulary Exception).*
- ☐ Windsor is charging a higher copayment for the drug I am prescribing than it charges for another drug that treats the same condition, and my patient should pay the lower copayment (Tiering Exception).*
- ☐ My patient has been taking 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 patient needs to be reimbursed for a covered prescription drug that he/she paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, you must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier or Non Formulary drugs. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs**.

Underwritten by Sterling Life Insurance Company. A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor.

Rationale for Exception Request or Prior Authorization:
NOTE: FORM CAN NOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

❑ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, 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 for drug(s). ***Please provide Supporting Documentation (i.e. office visit notes related to this request only, labs, etc.) along with this form.***

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❑ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change.
→Specify below: Anticipated significant adverse clinical outcome. ***Please provide Supporting Documentation (i.e. office visit notes related to this request only, labs, etc.) along with this form.***

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❑ Medical need for different dosage form &/or higher dosage that exceeds the FDA recommended dosage.
→Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason. ***Please provide Supporting Documentation (i.e. office visit notes related to this request only, labs, etc.) along with this form.***

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❑ Request for formulary TIER exception (Not allowed for specialty or preferred tiers)
→Specify below: (1) Formulary or preferred drugs contraindicated or tried & failed, or tried & 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. ***Please provide Supporting Documentation (i.e. office visit notes related to this request only, labs, etc.) along with this form.***

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❑ Other Requests: ____
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❑ **CHECK HERE TO REQUEST FOR EXPEDITED REVIEW [24 HOURS]**
By checking this box and signing below, I certify, as the prescriber of this medication, that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

NOTE: For Standard Coverage Determination will be made in 72 hours. Expedited Coverage Determinations will be made in 24 hours. Exception requests must be submitted with a supporting statement or documentation before timeframes begin. Information on this form is protected health information and subject to all privacy and security regulations under HIPAA

Physician Name: ____ Phone #: ______________

Physician Signature: ____________________________________ Date: ________________
(required for all requests)