



REQUEST FOR MEDICARE DRUG COVERAGE DETERMINATION

Use this form to ask our plan for a coverage determination. You can also ask for a coverage determination by phone at 833-251-9739 or through our website at ccama.org. You, your doctor or prescriber, or your authorized representative can make this request.

Plan Enrollee

Name	Date of birth
Street address	City
State	ZIP
Phone	Member ID #

If the person making this request isn't the plan enrollee or prescriber:

Requestor's name
Relationship to plan enrollee
Street address (include City, State and ZIP)
Phone
<input type="checkbox"/> Submit documentation with this form showing your authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or equivalent). For more information on appointing a representative, contact our plan or call 1-800-MEDICARE. (1-800-633-4227). TTY users can call 1-877-486-2048.

Name of drug this request is about (include dosage and quantity information if available)

Type of Request

- ☐ My drug plan charged me a higher copayment for a drug than it should have
- ☐ I want to be reimbursed for a covered drug I already paid for out of pocket
- ☐ I'm asking for prior authorization for a prescribed drug (this request may require supporting information)

For the types of requests listed below, your prescriber MUST provide a statement supporting the request. Your prescriber can complete pages 3 and 4 of this form, "Supporting Information for an Exception Request or Prior Authorization."

- ☐ I need a drug that's not on the plan's list of covered drugs (formulary exception)
- ☐ I've been using a drug that was on the plan's list of covered drugs before, but has been or will be removed during the plan year (formulary exception)
- ☐ I'm asking for an exception to the requirement that I try another drug before I get a prescribed drug (formulary exception)
- ☐ I'm asking for an exception to the plan's limit on the number of pills (quantity limit) I can get so that I can get the number of pills prescribed to me (formulary exception)
- ☐ I'm asking for an exception to the plan's prior authorization rules that must be met before I get a prescribed drug (formulary exception).
- ☐ My drug plan charges a higher copayment for a prescribed drug than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception)
- ☐ I've been using a drug that was on a lower copayment tier before, but has or will be moved to a higher copayment tier (tiering exception)

Additional information we should consider (*submit any supporting documents with this form*):

Do you need an expedited decision?

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'll automatically give you a decision within 24 hours. If you don't get your prescriber's support for an expedited request, we'll decide if your case requires a fast decision. (You can't ask for an expedited decision if you're asking us to pay you back for a drug you already received.)

- ☐ **YES, I need a decision within 24 hours.** If you have a supporting statement from your prescriber, attach it to this request.

Signature:

Date:

How to submit this form

Submit this form and any supporting information by mail or fax:

Address:

CVS Caremark Part D, Appeals and Exceptions

P.O. Box 52000, MC109

Phoenix, AZ 85072-2000

Fax Number:

1-855-633-7673

Supporting Information for an Exception Request or Prior Authorization To be completed by the prescriber

☐ **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 Information

Name	
Street Address (Include City, State and ZIP	
Office phone	
Fax	
Signature	Date

Diagnosis and Medical Information

Medication:	Strength and route of administration:	
frequency:	Date started: <input type="checkbox"/> NEW START	
Expected length of therapy:	Quantity per 30 days:	
Height/Weight:	Drug allergies:	
DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes (If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)		ICD-10 Code(s)
Other RELEVANT DIAGNOSES:		ICD-10 Code(s)

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	DATES of Drug Trials	RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY

Any **FDA NOTED CONTRAINDICATIONS** to the requested drug? ☐ YES ☐ NO

Any concern for a **DRUG INTERACTION** when adding the requested drug to the enrollee's current drug regimen? ☐ YES ☐ NO

If the answer to either of the questions above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety

HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY

If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ YES ☐ NO

OPIOIDS – (answer these 4 questions if the requested drug is an opioid)

What is the daily cumulative Morphine Equivalent Dose (**MED**)?
mg/day

Are you aware of other opioid prescribers for this enrollee?
If so, please explain. ☐ YES ☐ NO

Is the stated daily MED dose noted medically necessary? ☐ YES ☐ NO

Would a lower total daily MED dose be insufficient to control the enrollee's pain? ☐ YES ☐ NO

RATIONALE FOR REQUEST

☐ **Alternate drug(s) previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** [If not noted in the DRUG HISTORY section, specify below: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed]

☐ **Alternative drug(s) contraindicated, would not be as effective or likely to cause adverse outcome.** A specific explanation why alternative drug(s) would not be as effective or anticipated significant adverse clinical outcome and why this outcome would be expected is required. If contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated

☐ **Patient would suffer adverse effects if he or she were required to satisfy the prior authorization requirement.** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required.

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]

☐ **Request for formulary tier exception** If not noted in the DRUG HISTORY section, specify below: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐ **Other** (explain below)

CCA Senior Care Options (HMO D-SNP) is a Dual Special Needs Plan (D-SNP) with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 833-251-9739 (TTY 711).

You can get this document for free in other formats, such as large print, braille, or audio. Call 833-251-9739 (TTY 711), 24 hours a day, seven days a week. The call is free.

Notice of Nondiscrimination

Commonwealth Care Alliance, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of, or exclude people or treat them differently because of, medical condition, health status, receipt of health services, claims experience, medical history, disability (including behavioral impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence.
Commonwealth Care Alliance, Inc.:

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

If you need these services, contact Member Services.

If you believe that Commonwealth Care Alliance, Inc. has failed to provide these services or discriminated in another way based on medical condition, health status, receipt of health services, claims experience, medical history, disability (including behavioral impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence, you can file a grievance with:

Commonwealth Care Alliance, Inc.
Civil Rights Coordinator
30 Winter Street, 11th Floor
Boston, MA 02108
Phone: 617-960-0474, ext. 3932 (TTY 711) Fax: 857-453-4517
Email: civilrightscordinator@commonwealthcare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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 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, D.C. 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

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

Notice of Availability Interpreter Services

English: If you speak English, free language assistance services are available. Auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 833-251-9739 (TTY: 711).

Spanish: Si habla español, tiene a su disposición servicios de asistencia lingüística gratuitos. También están disponibles sin costo recursos auxiliares y servicios para proporcionar información en formatos accesibles. Llame al 833-251-9739 (TTY: 711).

Chinese Mandarin: 如果您讲普通话，我们可以提供免费的语言协助服务。此外，还免费提供以无障碍格式提供信息的辅助工具和服务。请致电 833-251-9739 (TTY: 711)。

Chinese Cantonese: 如果您講粵語，我們可以提供免費的語言協助服務。此外，還免費提供以無障礙格式提供資訊的輔助工具和服务。請致電 833-251-9739 (TTY: 711)。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit ang mga libreng serbisyo sa tulong sa wika. Ang mga pantulong na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang walang bayad. Tumawag sa 833-251-9739 (TTY: 711).

French: Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles. Des aides et services auxiliaires permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 833-251-9739 (TTY : 711).

Vietnamese: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí. Các dịch vụ và phương tiện phụ trợ cung cấp thông tin ở định dạng dễ tiếp cận cũng được miễn phí. Gọi 833-251-9739 (TTY: 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachunterstützungsdienste zur Verfügung. Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie die Nummer +833-251-9739 (TTY: 711) an.

Korean: 한국어를 구사하는 경우, 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하는 보조 도구와 서비스도 무료로 제공됩니다. 833-251-9739 (TTY: 711) 으로 전화하세요.

Russian: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Звоните по номеру 833-251-9739 (TTY: 711).

Arabic: إذا كنت تتحدث اللغة العربية، تتوفر خدمات المساعدة اللغوية المجانية. وتتوفر أيضًا مساعدات وخدمات إضافية لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجاناً. اتصل على الرقم 833-251-9739 (TTY: 711).

Hindi: यदि आप हिन्दी बोलते हैं, तो निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ परास्त्र में सूचना उपलब्ध कराने के लिए सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 833-251-9739 (TTY: 711) पर कॉल करें।

Italian: Se parla italiano, può usufruire di servizi di assistenza linguistica gratuiti. Sono disponibili gratuitamente anche dei servizi e supporti ausiliari che forniscono informazioni in formati accessibili. Chiama il numero 833-251-9739 (TTY: 711).

Portuguese: se você fala português, serviços de assistência linguística gratuitos estão disponíveis. Recursos e serviços auxiliares para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 833-251-9739 (TTY: 711).

Cape Verdean Creole: Si bu ta papia Kriolu di Kabu Verdi, sirvisus di apoiu lingustikui ta sta dispunível. També ta sta dispunível apoiu y sirvisus ausiliaris pa da informason na formatus asesível. Txoma pa 833-251-9739 (TTY: 711).

Haitian Creole: Si ou pale kreyòl Ayisyen, gen sèvis asistans lang gratis ki disponib. Gen èd ak sèvis oksilyè pou bay enfòmasyon nan fòma aksesib ki disponib gratis tou. Rele 833-251-9739 (TTY: 711).

Polish: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 833-251-9739 (TTY: 711).

Japanese: 日本語を話せる方は、無料の言語支援サービスをご利用いただけます。受け入れ可能な方法で情報を入手するための補助手段やサービスも無料でご利用いただけます。833-251-9739 (TTY: 711) にお電話ください。

Gujarati: જો તમે ગુજરાતી બોલનાર છો, તો મફત ભાષા સહાય સેવા ઉપલબ્ધ છે. માહિતીને સુલભ ફોર્મેટમાં પરદાને કરવા માટે સહાયક સહાય અને સેવા પણ મફતમાં ઉપલબ્ધ છે. 833-251-9739 (TTY: 711) પર કૌલ કરો.

Lao/Laotian: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພາສາລາວ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການພ້ອມສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນບໍ່ມີຄ່າສາມາດໃຊ້ໄດ້ໃດໆເປັນເປັນ. ໂທ 833-251-9739 (TTY: 711).

Greek: Εάν μιλάτε ελληνικά, διατίθενται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Διατίθενται επίσης δωρεάν βοηθητικά μέσα και υπηρεσίες για την παροχή πληροφοριών σε προσβάσιμη μορφή. Καλέστε στο 833-251-9739 (TTY: 711).

Khmer: រាល់និយោជិតនៃក្រុមហ៊ុននេះ មានសិទ្ធិទទួលបានសេវាជំនួយភាសា ឥតគិតថ្លៃ។ សេវាជំនួយភាសា គឺជាសេវាដែលផ្តល់ជូនដល់អ្នកដែលមានការពិការភាពភាសា ដើម្បីឱ្យពួកគេអាចទទួលបានព័ត៌មាន និងសេវាផ្សេងៗទៀតបាន។ បើសិនជាអ្នកមានការពិការភាពភាសា ឬការពិការភាពផ្សេងៗទៀត ដែលបង្កឱ្យមានការពិបាកក្នុងការទទួលបានព័ត៌មាន និងសេវាផ្សេងៗទៀត ទូរសព្ទ ទៅ 833-251-9739 (TTY: 711)។