

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 1-833-866-6559 (TTY: 1-800-955-8770) or through our website at www.fhcpmedicare.com/contact-us. 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)

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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:
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How to submit this form

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

Address:
FHCP Medicare
Attn: Member Services
P.O. Box 9910
Daytona Beach, FL 32120
Y0011_FHCP0405_2024_C

Fax Number:
386-676-7149

**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 RELAVENT 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)

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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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any concern for a DRUG INTERACTION when adding the requested drug to the enrollee's current drug regimen?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO

OPIOIDS – (answer these 4 questions if the requested drug is an opioid)	
What is the daily cumulative Morphine Equivalent Dose (MED)?	<input type="text"/> mg/day
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the stated daily MED dose noted medically necessary?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	<input type="checkbox"/> YES <input type="checkbox"/> 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)

HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association.

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide:

- People with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language assistance services to people whose primary language is not English, which may include:
 - Qualified Interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact:

- Florida Health Care Plans (Group & Individual): 1-877-615-4022
- FHCP Medicare: 1-833-866-6559

If you believe that we have 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 with:

Florida Health Care Plans (Group & Individual members):

Florida Health Care Plans
Civil Rights Coordinator
PO Box 9910
Daytona Beach, FL 32120-0910
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149,
Email: rights@fhcp.com

FHCP Medicare members:

FHCP Medicare
Civil Rights Coordinator
PO Box 9910
Daytona Beach, FL 32120-0910
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149
Email: rights@fhcp.com

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 <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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-877-615-4022, a Medicare al 1-833-866-6559, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòm ki disponib gratis. Rele nan 1-877-615-4022, oswa rele Medicare nan 1-833-866-6559 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-877-615-4022 医疗保险 (Medicare) 1-833-866-6559 听障专线 (TTY) 711。

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-877-615-4022, le Medicare au 1-833-866-6559 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-877-615-4022, Medicare 1-833-866-6559 (номер для текст-телефонных устройств (TTY) 711).

الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على
1-877-615-4022 برنامج Medicare: 1-833-866-6559 (TTY: 711) لذوي الإعاقة السمعية)

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-877-615-4022, Medicare: 1-833-866-6559, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-877-615-4022, 메디케어 1-833-866-6559, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફોર્મટ સેવાઓ ઉપલબ્ધ છે.
1-877-615-4022, Medicare 1-833-866-6559, (TTY 711) પર કોલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。1-877-615-4022、メディケア 1-833-866-6559 (TTY 711) までお電話ください。

T'áá free yíníłta'go saad bee áká anilyeedígíí, alk'ida'ánígíí, dóo t'áá ajiłii hane' bee áká anilyeedígíí t'éiyá éí hołne'. 1-877-615-4022 bich'į' náhodoonih, Medicare bich'į' 1-833-866-6559 bich'į' náhodoonih, (TTY 711).