Neighborhood Health Plan OF RHODE ISLAND™

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

Address:
CVS Caremark
Appeals Dept.
MC109
PO BOX 52000
Phoenix, AZ 85072-2000

Fax Number Standard: 1-855-829-2875

You may also ask us for a coverage determination by phone at 1-844-812-6896.
TTY/TTD users should call 711 or go to our website at www.nhpri.org/INTEGRITY.

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).*

☐I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

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***NOTE: If you are asking for a formulary 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 INSTEAD OF THE STANDARD 72 HOUR REVIEW (attach the prescriber's supporting statement to this request).**

Signature:	**Date:**
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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.

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]

☐ **Other** (explain below)

Required Explanation _____

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Neighborhood Health Plan of Rhode Island is a health plan that contracts with both Medicare and Rhode Island Medicaid to provide the benefits of both programs to enrollees.

You can get this information for free in other languages. Please call our Member Services at 1-844-812-6896 (TTY 711), 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

Esta información está disponible de forma gratuita en otros idiomas. Por favor llame a nuestro Departamento de Servicios para Miembros al 1-844-812-6896 (TTY 711) de 8 am a 8 pm, lunes-viernes; sábados de 8 am a 12 pm. Los sábados por la tarde, domingos y días festivos federales, se le pedirá que deje un mensaje. Su llamada será devuelta dentro del siguiente día laborable. La llamada es gratuita.

Estas informações estão disponíveis gratuitamente noutros idiomas. Por favor telefone para os Serviços dos Membros em 1-844-812-6896 (TTY 711), das 8 às 20 horas, de Segunda a Sexta-feira; e das 8 às 12 (meio-dia) aos Sábados. Nos Sábados à tarde, Domingos e feriados federais, poderá ser-lhe pedido que deixe uma mensagem. A sua chamada será respondida no próximo dia útil. Esta chamada é grátis.

Limitations and restrictions may apply. This means that you may have to pay for some services and that you need to follow certain rules to have Neighborhood INTEGRITY pay for your services. For more information, call Neighborhood INTEGRITY Member Services or read the Neighborhood INTEGRITY Member Handbook.

Benefits as well as the List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.