



**REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION**

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

Address:  
Tufts Health Plan Senior Care Options  
Attn: Pharmacy Utilization Management Department  
1 Wellness Way  
Canton, MA 02021-1166

Fax Number: 1-617-673-0956

Online Prior Authorization:  
<https://point32health.promptpa.com>

You may also ask us for a coverage determination by phone at 1-855-670-5934, (TTY: 711) or through our website at [tuftsmedicarepreferred.org/sco](http://tuftsmedicarepreferred.org/sco).

**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 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).\*
- My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).\*
- I have been using 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 drug plan charged me a higher copayment for a drug than it should have.
- I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

**\*NOTE: If you are asking for a formulary or tiering 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 (if you have a supporting statement from your prescriber, attach it to this request).**

<b>Signature:</b>	<b>Date:</b>
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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.

**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.**

<b>Prescriber's Information</b>			
Name			
Address			
City	State	Zip Code	
Office Phone	Fax		
Prescriber's Signature			Date

<b>Diagnosis and Medical Information</b>		
Medication:	Strength and Route of Administration:	Frequency:
Date Started: <input type="checkbox"/> <b>NEW START</b>	Expected Length of Therapy:	Quantity per 30 days
Height/Weight:	Drug Allergies:	

<b>DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes.</b> (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)
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<b>Other RELAVENT DIAGNOSES:</b>	ICD-10 Code(s)
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**DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)**

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

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** with the addition of the requested drug to the enrollee's current drug regimen?  YES  NO

If the answer to either of the questions noted 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 – (please complete the following 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?  YES  NO  
 If so, please explain.

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) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (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, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
- 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 a significant adverse 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** Specify below if not noted in the DRUG HISTORY section earlier on the form: (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), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
- Other** (explain below)

**Required Explanation** \_\_\_\_\_

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Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

**Tufts Health Plan:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - 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 Tufts Health Plan at 1-855-670-5934 (TTY: 711).

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

**Tufts Health Plan, Attention:**

Civil Rights Coordinator, Legal Dept.  
1 Wellness Way, Canton, MA 02021  
Phone: 1-888-880-8699 ext. 48000, (TTY: 711)  
Fax: 1-617-972-9048  
Email: [OCRCoordinator@point32health.org](mailto:OCRCoordinator@point32health.org)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan 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 (TDD: 1-800-537-7697)

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

[www.thpmp.org/sco](http://www.thpmp.org/sco) | 1-855-670-5934 (TTY: 711)



a Point32Health company

## Multi-language Interpreter Services

**English:** We have free interpreter services available for people who require translation services to answer any questions you may have about our health or drug plan. We can also give you information in English, braille, large print, or other alternate format. Just call us at 1-855-670-5934. Someone who speaks English can help you. This is a free service.

**Spanish:** Contamos con servicios gratuitos de intérpretes disponibles para personas que requieren servicios de traducción para responder cualquier pregunta que usted pueda tener sobre nuestro plan de salud o medicamentos. También podemos brindarle información en español, braille, letra grande u otro formato alternativo. Simplemente llámenos al 1-855-670-5934. Una persona que habla español le puede ayudar. Este es un servicio gratuito.

**Chinese Simplified:** 我们为需要翻译服务的人提供免费口译服务，回答您对我们的健康或药物计划的任何问题。我们还可以以简体中文、盲文、大字体或其他替代格式为您提供信息。请致电 1-855-670-5934 联系我们。会说普通话的人会帮助您。本项服务免费。

**Chinese Traditional:** 我們為有翻譯服務需求者提供免費口譯服務，以針對我們的健康或藥物計劃，為您回答任何您可能提出的問題。我們也以繁體中文、點字、大字體或其他替代格式為您提供資訊。請撥打電話：1-855-670-5934。會說中文的人可以協助您。此為免費服務。

**Tagalog:** Mayroon kaming mga libreng serbisyo ng interpreter na magagamit ng mga taong nangangailangan ng mga serbisyo ng pagsasalín upang masagot ang anumang maaaring tanong mo tungkol sa aming plano sa kalusugan o gamot. Maaari din kaming magbigay sa iyo ng impormasyon na nasa Tagalog, braille, malalaking titik, o iba pang alternatibong format. Tumawag lang sa amin sa 1-855-670-5934. Matutulungan ka ng isang taong nagsasalita ng Tagalog. Isa itong libreng serbisyo.

**French:** Nous mettons des services d'interprétariat gratuits à la disposition de tous ceux qui ont besoin de services de traduction pour répondre aux questions que vous pourriez poser sur notre régime d'assurance-maladie ou médicaments. Nous pouvons vous fournir des informations en français, braille, lettres majuscules, ou tout autre format. Veuillez nous appeler au 1-855-670-5934. Une personne qui parle français pourra vous assister. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí cho người cần phiên dịch để trả lời bất kỳ câu hỏi nào mà quý vị có thể có về chương trình bảo hiểm y tế hay chương trình thuốc của chúng tôi. Chúng tôi cũng có thể cung cấp thông tin cho quý vị bằng Tiếng Việt, chữ nổi braille, bản in chữ lớn, hay định dạng thay thế khác. Quý vị chỉ cần gọi chúng tôi theo số 1-855-670-5934. Một người nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

**German:** Wir stellen Dolmetscherdienste kostenlos all jenen zur Verfügung, die zwecks Beantwortung ihrer Fragen zu den für sie geltenden Kostenübernahme- und Zuzahlungsregeln Übersetzungsdienste benötigen. Zudem informieren wir Sie bei Bedarf in Deutsch, Brailleschrift, Großdruck oder anderen Formaten. Rufen Sie uns einfach an: 1-855-670-5934. Hier erhalten Sie Hilfe von jemand, der Deutsch spricht. Dieser Service ist kostenlos.

**Korean:** 번역 서비스가 필요하신 분들에게 건강 플랜 또는 약품 플랜에 대한 문의에 답변을 드리기 위해 무료 통역 서비스를 제공합니다. 또한 한국어, 점자, 큰 활자 또는 기타 대체 형식으로 정보를 제공할 수 있습니다. 1-855-670-5934번으로 전화해 주십시오. 한국어를 구사하는 사람이 도와드릴 수 있습니다. 통역은 무료 서비스입니다.

**Russian:** Мы предоставляем бесплатную услугу устного перевода для людей, которым он необходим, чтобы ответить на вопросы о здоровье или плане получения рецептурных препаратов. Мы также можем предоставить вам информацию на русском языке, с использованием шрифта Брайля, крупным шрифтом или в другом альтернативном формате. Просто позвоните по номеру 1-855-670-5934. Вам поможет сотрудник, владеющий русским языком. Это — бесплатная услуга.

**Arabic:** لدينا خدمات ترجمة فورية مجانية متاحة للأشخاص الذين يحتاجون إلى خدمات الترجمة للإجابة عن أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. يمكننا أيضًا تزويدك بالمعلومات باللغة العربية أو بطريقة برايل أو بحروف كبيرة أو بأي تنسيق بديل آخر. كل ما عليك هو الاتصال بنا على الرقم 1-855-670-5934. يمكن أن يقوم شخص يتحدث باللغة العربية بمساعدتك. هذه الخدمة مجانية.

**Hindi:** हमारे पास उन लोगों के लिए मुफ्त दुभाषिया सेवाएं उपलब्ध हैं जिन्हें हमारी स्वास्थ्य या दवा योजना के बारे में उनके किसी भी प्रश्न का उत्तर देने के लिए अनुवाद सेवाओं की आवश्यकता है। हम आपको हिंदी, ब्रेल, बड़े प्रिंट या अन्य वैकल्पिक प्रारूप में भी जानकारी दे सकते हैं। बस हमें 1-855-670-5934 पर कॉल करें। हिन्दी बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

**Italian:** Se occorre una traduzione, i nostri servizi di interpretariato sono disponibili gratuitamente per offrire chiarimenti e risposte in merito al nostro piano sanitario o per i medicinali. Possiamo offrire informazioni anche in italiano, braille, caratteri grandi o altri formati. Non esiti a chiamarci al recapito 1-855-670-5934. Una persona che parla italiano sarà pronta a offrire assistenza. Questo servizio è gratuito.

**Portuguese:** Temos serviços de interpretação gratuitos para quem necessite de serviços de tradução para responder a qualquer questão que possamos ter sobre o seu plano de saúde ou medicação. Também podemos dar todas as informações em Português, braille, letra de grande dimensão ou formato alternativo. Basta ligar para o 1-855-670-5934. Alguém fala Português e poderá ajudar. É um serviço gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis ki disponib pou moun ki bezwen sèvis tradiksyon pou reponn nenpòt kesyon ou ka genyen sou plan sante ouwa anrapò ak plan medikaman nou an. Nou kapab ba w enfòmasyon tou nan lang Kreyòl ayisyen, bray, gwo lèt, ouwa lòt fòm. Jis rele nou nan 1-855-670-5934. Yon moun ki pale lang Kreyòl ayisyen ka ede w. Sa a se yon sèvis gratis.

**Polish:** Osobom potrzebującym tłumaczenia oferujemy bezpłatne usługi tłumacza, który odpowie na wszelkie pytania związane z naszym planem zdrowotnym lub dotyczącym leków. Możemy również udzielić informacji w języku polskim, alfabetcie Braille'a, dużym druku lub innym alternatywnym formacie. Wystarczy zadzwonić pod numer 1-855-670-5934. Ktoś mówiący w języku polskim może Ci pomóc. Jest to usługa bezpłatna.

**Japanese:** 私たちの医療や医薬品の計画に関する、どのような質問にもお答えするため、翻訳サービスが必要な方のための無料通訳サービスを提供しています。情報は、日本語、点字、大活字、その他の代替形式でも提供可能です。1-855-670-5934 にお電話ください。日本語対応でお手伝いたします。これは無料のサービスです。

**Khmer:** យើងមានសេវាកម្មអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃសម្រាប់អ្នក ដែលត្រូវការសេវាកម្មបកប្រែ ដើម្បីឆ្លើយសំណួរណាមួយដែលអ្នកអាចមាន ទាក់ទងនឹងគម្រោងសុខភាព ឬឱសថរបស់យើង។ យើងក៏អាចផ្តល់ជូនអ្នកនូវព័ត៌មានជាភាសា ខ្មែរ អក្សរសម្រាប់ជនពិការផ្នែក អក្សរពុម្ពធំ ឬជាទម្រង់ដទៃផ្សេងទៀតបានផងដែរ។ គ្រាន់តែហៅទូរសព្ទមកយើងតាមលេខ 1-855-670-5934 ។ អ្នកដែលនិយាយភាសា ខ្មែរ អាចជួយអ្នកបាន។ នេះជាសេវាកម្មមិនគិតថ្លៃនោះទេ។

**Laotian:** ພວກເຮົາມີການບໍລິການນາຍພາສາພຣີທີ່ມີໃຫ້ສໍາລັບຜູ້ທີ່ຕ້ອງການການບໍລິການການແປພາສາ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດ ຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ພວກເຮົາຍັງສາມາດໃຫ້ທ່ານເປັນຂໍ້ມູນໃນພາສາລາວ, ຕົວໜັງສືພື້ນ, ການພິມຂະ ໜາດໃຫຍ່ ຫຼື ຮູບແບບອື່ນໆ. ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ 1-855-670-5934. ຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການພຣີ.