HealthPartners®

Coverage Determination Request and Prior Authorization Form

This form is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. It can also be used by physicians or enrollees to satisfy a prior authorization or other utilization requirement, and/or to provide a supporting statement for an exception request.

Requests for coverage determinations and prior authorization can also be submitted to Member Services orally by calling one of the following numbers between 8 a.m. and 8 p.m., seven days a week. Freedom members should call 952-883-7979 or 1-800-233-9645. Classic members should call 952-883-7676 or 1-866-233-8734. All TTY users should call 952-883-6060 or 1-800-443-0156.

Please use the Coverage Determination Request Form:

- If you're not getting a prescription drug that you believe may be covered by your HealthPartners® Freedom Plan (Cost) or Classic Plan (HMO).
- If you've received a Part D prescription drug you believe may be covered by your HealthPartners® Freedom or Classic plan while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it's not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the copayment we require you to pay for a drug.
- If you're being told that coverage for a Part D prescription drug that you've been getting will be reduced or stopped.
- If there's a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- If there's a requirement that you try another drug before we'll pay for the drug you're requesting.
- You bought a drug at a pharmacy that's not in our network and you want to request reimbursement for the expense.

How to complete the Coverage Determination Request Form:

Step 1: Print the form on a printer so you can write on it.
Step 2: Complete all the questions on the form.
Step 3: Sign and date the form.
Step 4: **The Prescribing Physician's Information section must be completed, signed and dated by your physician. (Forms must include this information.)**
Step 5: Mail the form to: HealthPartners, P.O. Box 1309, Mail Stop: MR 21111B Minneapolis, MN 55440-1309. Or fax the form to us at 1-888-883-5434.

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Enrollee's/Requestor's Information

______________________________ ______________________________
Enrollee's Name Enrollee's Date of Birth

______________________________ ______________________________
Enrollee's Medicare Number Enrollee's Part D Plan ID Number

____
Requestor's Name (if not enrollee)

____
Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

____
Enrollee/Requestor's Address City State Zip Code

____
Phone

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

Prescribing Physician's Information

______________________________ ______________________________
Name Medical Specialty

____
Address City State Zip Code

________________ ________________ ________________
Work Phone Fax Office Contact Person

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 an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*

☐ I request prior authorization for the drug my doctor has prescribed.

☐ 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 doctor prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my doctor 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).*

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

☐ Other.

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

Additional information we should consider *(attach any supporting documents)*: If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

☐ I need an expedited coverage determination (attach physician's supporting statement, if applicable)

____ __________

Beneficiary/Requestor's Signature Date

See your Evidence of Coverage for more information on what is required for HealthPartners to make this determination. Or call Member Services at the numbers on the top of this form for more information.