BLUE CROSS AND BLUE SHIELD OF FLORIDA (BCBSF)
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 know, 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 co-payment 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.

***NOTE: 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*):

_____

_____

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_____

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

If you have any questions regarding this information, you may contact our Member Services Department at 1-877-352-2583 and a Member Service Representative will be happy to assist you. If you are a Member and are hearing and/or speech impaired, you may dial 711, for Spanish 1-877-955-8773, and for Creole 1-877-955-8707 via TTY. Our office hours are Monday through Thursday from 8:00 a.m. to 9:00 p.m. and on Friday from 9:00 a.m. to 9:00 p.m.

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information. You may fax this request to 1-305-716-9333 or if you choose you may mail this request to:

Blue Cross and Blue Shield of Florida
Medicare Part D Pharmacy Coverage Determinations
8400 NW 33rd Street, Suite 100
Miami, FL 33122-1932