

**REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION**

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

Address:  
PO Box 1039  
Appleton, WI 54912-1039

Fax Number:  
1-855-668-8552

You may also ask us for a coverage determination by phone at 1-844-269-3442 or 1-718-637-2075 (local) or through our website at [www.healthpointny.com](http://www.healthpointny.com).

**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):

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| <br><br><br><br><br><br><br><br><br><br> |
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**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> |
|-------------------|--------------|

## 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.

| 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:           |
| Date Started:<br><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><br><small>(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)</small> |                                       | ICD-10 Code(s)       |
| <b>Other RELEVANT DIAGNOSES:</b>  |                                       | ICD-10 Code(s)       |

| DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)                       |                      |  |
|--|----------------------|--|
| DRUGS TRIED<br><small>(if quantity limit is an issue, list unit dose/total daily dose tried)</small> | DATES of Drug Trials | RESULTS of previous drug trials<br><b>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?  
If so, please explain.  **YES**  **NO**

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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\_\_\_\_\_



***Health Pointe Direct Complete Plan (HMO I-SNP) is required by federal law to provide the following information.***

Health Pointe Direct Complete Plan (HMO I-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Health Pointe Direct Complete Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Customer Care Center at 1-844 269-3442.

If you believe that Health Pointe Direct Complete Plan (HMO I-SNP) has 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. If you need help filing a grievance, The Grievance Department is available to help you. You can file a grievance in person or by mail, fax, or email:

Grievance Department  
810 7<sup>th</sup> Ave, Suite 801  
New York, NY 10019  
Phone: 1-844-269-3442  
Email: [Grievance@healthpointeny.com](mailto:Grievance@healthpointeny.com)

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>.

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-269-3442 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-269-3442 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1-844-269-3442 (TTY 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-844-269-3442 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-269-3442 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-269-3442 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ không dịch miễn phí để trả lời các câu hỏi về chương trình bảo hiểm thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-844-269-3442 (TTY 711). sẽ nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-269-3442 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-269-3442 (TTY 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.



**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-269-3442 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:**

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. سيقوم شخص ما يتحدث 24439624481 للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على. ميساعدتك. هذه خدمة مجانية للأعرابية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-269-3442 (TTY 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-269-3442 (TTY 711). Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-269-3442 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal ouwa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-269-3442 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-269-3442 (TTY 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-844-269-3442 (TTY 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。