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## Medica Dual Solution<sup>SM</sup> & AccessAbility Solution<sup>SM</sup>

### Medicare Part D Coverage Determination Request Form

This form **cannot** be used to request:

- Medicare & Medicaid non-covered drugs including fertility drugs, erectile dysfunction drugs, drugs prescribed for weight loss, weight gain, hair growth, or other cosmetic indications.

This form **can be** used to request:

- Part D Eligible Drugs that are non-formulary, to override a quantity limit or step therapy requirement, or to meet a prior authorization requirement
- Part B Eligible Drugs that are provided by a network pharmacy
- OTC medications that are not on Medica's OTC covered drug list
- Non Part D drugs covered under member's Medicaid benefits (Ex diazepam)

<b>Plan Name:</b> (Circle One)	<b>Medica Dual Solution (MSHO)</b> (H2458)	or	<b>Medica AccessAbility Solution</b> (H7526)
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Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Member ID#		DEA#		
Address:		Address:		
City:	State	City:	State:	Zip:
Home Phone:	Zip:	Office Phone#	Office Fax:	
Sex (circle): M   F	DOB:	LTC Facility (√) <input type="checkbox"/>	Contact Person (MD's Office) or Care Coordinator:	If Care System Care Coordinator Check Here <input type="checkbox"/>

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
Prescriber's Signature:		Date:

Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION
<p><b>Alternate drug(s)</b> contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure) <i>Specify below:</i> (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);</p> <p><b>Complex patient with one or more chronic conditions</b> (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change <i>Specify below:</i> Anticipated significant adverse clinical outcome</p> <p><b>Medical need for different dosage form and/or higher dosage</b> <i>Specify below:</i> (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason</p> <p><b>Request for formulary tier exception</b> <i>Specify below:</i> (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome</p> <p><b>REQUIRED EXPLANATION:</b> _____ _____ _____</p>

#### Request for Expedited Review (24 Hours)

<input type="checkbox"/>	BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION
<b>Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA</b>	