



10680 Trenea Street Suite 500  
San Diego, CA 92131

Phone: (800) 681-9574  
Fax: (858) 790-7100

### Medica Dual 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>	<b>Medica Dual Solution (MSHO) (H2458)</b>
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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

**Alternate drug(s)** contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure)  
**Specify below:** (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

**Complex patient with one or more chronic conditions** (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change

**Specify below:** Anticipated significant adverse clinical outcome

**Medical need for different dosage form and/or higher dosage**

**Specify below:** (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

**Request for formulary tier exception**

**Specify below:** (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

**REQUIRED EXPLANATION:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Request for Expedited Review (24 Hours)

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

**Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA**

**MEDICA**<sup>®</sup>



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