PerformRx
The Next Generation PBM
A division of AmeriHealth Mercy

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 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 co-payment (tiering exception).*

☐ I have been using a drug that was previously included on a lower co-payment tier, but is being moved to or was moved to a higher co-payment 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 co-payment 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

Return this form to: PerformRx
200 Stevens Drive
Philadelphia, PA 19113
Attention: Pharmacy Prior Authorization/Member Prescription Coverage Determination