MEDICARE PART D MEDICATION REQUEST FORM (*CareAdvantage*)

HealthPlan OF SAN MATEO

Health Plan of San Mateo
Attn: Pharmacy Services
Fax: 650-829-2045

Instructions:
This form is to be used by participating physicians, providers and *CareAdvantage* members/appointed representatives to request coverage for a Medicare Part D Medication. Please complete this form and fax to **Health Plan of San Mateo** at **650-829-2045.** If you have any questions regarding this process, please contact **HPSM Pharmacy Help Line** at **650-616-2088.**

Who is making the request? Physician ☐ Member/Appointed Representative ☐ Pharmacy ☐

An **Expedited Request*** is one where applying the standard timeframe for response (72-hour) could seriously jeopardize patient life health or ability to recover. For Expedited requests (24 hour review) please provide relevant information.
Formulary Exception Requests require a written Physician Supporting Statement with the following information included:

1. Failure of an appropriate trial (include drug name, dose and duration) of Formulary agents, or
2. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety
3. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care
4. The use of Formulary Drug Product is contraindicated in the patient.
5. The use of the Formulary Drug Product would not be as effective as the requested drug: and/or would have adverse effects.(Copay/Tier Exceptions)

Medication Request Information (please complete each section of this form prior to transmittal):

Date	Request submitted by (Name and relationship to patient)
Patient Name (required):	☐ Standard Request ☐ Expedited Request *(must meet CMS definition* to qualify)*
Patient ID # (required): **CAA** || **CAB**	Physician Name (Required) | Specialty - ☐ Psych || ☐ Other
Patient Phone # (required)	Physician NPI#/DEA # (Required):: Physician Area Code and Telephone Number (required): ( ) -
Patient DOB (required):	Physician Area Code and Fax Number (required): ( ) -
Diagnosis (required):	Pharmacy Area Code and Telephone and FAX Number: ( ) - ; ( )
Pharmacy used by Member:	
Drug Requested *(For Concurrent Atypical Antipsychotic requests, please also submit a Brief Psychiatric Rating Scale - **BPRS** Form)*	
Dose:	Length of Treatment (**please be specific**):
Strength: Quantity (per month):	Dosage Form (e.g. Oral, Injection):
Reason for Medication Request (**required - please be specific, give detail**):	
Other Medications Tried and/or Failed (**required - please be specific, give detail**):	
Is the patient currently on this medication (**required - please be specific, give detail**):	
Other Pertinent History, Diagnosis (required - relative or pertaining to this request):	

Physician Signature: _____M.D. **Date**:_____
*(Please fill out and sign Appointment of Representative, **AOR**, form if MRF is NOT completed by a physician)*