Request for Prescription Information or Change
Medicare Prescription Drug Coverage
Provider Communication Form

TO: (Prescriber): __________________________ Date: __________________________
Fax: __________________________ Phone: __________________________

Patient Name: ___________________________________________
Name of Drug Plan: __________________________ Plan Phone (if available): __________________________
Member Number: __________________________ Prescription Number: __________________________

PRESCRIPTION ISSUES
☐ The patient’s drug plan has indicated that it will not pay for __________________________ for this patient because:
  ☐ Prior authorization required
  ☐ Step therapy required. Plan will pay for __________________________
  ☐ Plan only authorizes __________________________ dosage units (tablets/capsules) per prescription
  ☐ Plan does not pay for dosage/format prescribed
  ☐ Drug is not on the formulary. NOTE:
    ☐ Plan authorized one-time only payment for this drug
    ☐ Plan did not authorize one-time payment
    ☐ Other drugs on the formulary include (if available): __________________________

☐ Other reason(s) ___________________________________________

☐ The patient’s drug plan covers this drug, but with a higher co-pay. Preferred drugs available at lower co-pay (if available): __________________________

☐ ACTION REQUESTED – Please Respond To Pharmacy:
  Pharmacist Requesting Action: __________________________
  ☐ Urgent - patient is waiting
  ☐ By next refill: __________________________ (Date)
  ☐ Provide alternative medication: __________________________
  ☐ Other recommended action: __________________________
  
  For Fax Back:
  Prescriber Signature: __________________________ Date: __________

☐ ACTION REQUESTED – Contact Drug Plan to Request: ☐ prior authorization ☐ formulary exception

☐ INFORMATION ONLY - No Immediate Action Necessary

FROM:
Pharmacy Name: __________________________ Fax: __________________________ Phone: __________________________
E-mail: __________________________ Address: __________________________

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.
Use of this form is endorsed by the Alzheimer’s Association, American Medical Association, American Pharmacists Association, Center for Medicare Advocacy, Medical Group Management Association, National Community Pharmacists Association and the National Council on the Aging

The Centers for Medicare & Medicaid Services has reviewed this fax form, but does not require its use. Use of the form for communications between pharmacists and prescribers is voluntary. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

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