

MEDICARE PART D TIER EXCEPTION INFORMATION

Please fax or mail the attached form to:

TOLL FREE

Fax: 800-693-6703 Phone: 800-693-6651

Prime Therapeutics LLC

Attn: Medicare Appeals Department

1305 Corporate Center Drive

Eagan, MN 55121

Please read all instructions below before completing the attached form.

- Please complete the attached Request for a Lower Copay* (Tier Exception Form)
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: **800-693-6703**. It is not necessary to fax this cover page.

Information about this Request for a Lower Copay (Tier Exception)

Use this form to request coverage of a brand or generic in a higher cost sharing tier at a lower cost sharing tier. Certain restrictions apply**.

To process this request, documentation that all of the drugs to treat the same medical condition on the lower cost sharing tier have been previously tried, would not be as effective or would have adverse effects must be provided. Please provide clinical information or other evidence supporting the medical necessity of the drug on the higher cost sharing tier.

****Please note:** Centers for Medicare & Medicaid Services (CMS) prohibits the request of a Tier Exception for a medication already approved for Formulary Exception.

You can expedite this request by indicating its urgency at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously harm the member's life, health, or ability to regain maximum function.

*Copay, copayment, or coinsurance means the amount a patient pays each time they fill a prescription. This amount may vary depending on the drug payment stage (deductible, initial coverage, coverage gap, catastrophic coverage) the patient is in.

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and contains information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 800-858-0723, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.

**MEDICARE PART D
TIER EXCEPTION
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form. This form is for Medicare Part D prospective, concurrent, and retrospective reviews.

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The following documentation is **REQUIRED**. For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary. To submit this form electronically, please click [here](#) or go to covermymeds.com.

Per CMS requirements – all standard requests are completed within 72 hours (including weekends)

If you request an expedited review and sign this form, you certify that applying the 72 hour standard review time frame could seriously harm the patient's life, health or ability to regain maximum function. Please check the box to request an expedited review:

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION

Today's Date: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:		Patient Telephone Number:	
Prescribing Physician's Name:	Physician NPI#:	Specialty:	Clinic Contact Person's Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Clinic Phone #:	Clinic Secure Fax #:
Is the patient a long term care facility resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:		LTC Phone #:	LTC Secure Fax #:
Diagnosis- ICD code plus description:			Patient's Weight (kg)
Medication Requested:		Strength:	
Dosing Schedule:		Quantity per Month:	
Is the patient currently treated with the requested medication (i.e this request is for a refill)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
List ALL previously attempted lower-tier drugs and indicate any adverse effects requiring discontinuation. Please provide dates of use:			
1. _____ 2. _____ 3. _____ 4. _____			
If no available lower-tier alternatives have been previously tried, please check this box: <input type="checkbox"/>			
Medical Justification: Please provide medical justification for the lower copay drug exception request. Please address why ALL lower-tier alternatives not yet attempted for treatment of the same condition would not be as effective or would cause adverse effects.			
If all lower-tier agents would not be as effective or would have adverse effects, please provide clinical rationale for perceived ineffectiveness or adverse effects for each available lower-tier alternative: _____			

* For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary.			
I attest that the information provided on this form is true and accurate as of this date:			
Prescriber's signature: _____		Date: _____	

MyPrime is a pharmacy benefit website owned and operated by Prime Therapeutics LLC, an independent company providing pharmacy benefit management services. Blue Cross MedicareRx is a prescription drug plan provided by HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.