

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

TODAY'S OPTIONS®

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Request for a Lower Co-pay (Tiering Exception): Please respond.

- Please complete the attached Request for a Lower Co-pay (Tiering Exception Form)
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this Request for a Lower Co-pay (Tiering Exception)

Use this form to request coverage of a Nonpreferred Brand (Tier 3) drug at the lower Preferred Brand (Tier 2) co-pay. To process this request, documentation that all of the Tier 2 alternatives would not be as effective or would have adverse effects must be provided. Please provide clinical information or other evidence to support the medical necessity of the Nonpreferred Brand (Tier 3) drug, including previous Preferred Brand (Tier 2) drugs attempted for this patient's condition. Please note: Preferred Brand (Tier 2) and Specialty Tier drugs are not eligible for tier exceptions.

You can make an expedited request by indicating this 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 jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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Request for a Lower Co-pay (Tiering Exception)

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Patient Information

Name _____
 Member ID _____
 Medicare ID _____
 Date of birth _____ Sex: M / F
 Address _____
 City _____
 State _____ ZIP _____
 Phone _____
 Nursing home resident? YES / NO
 Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
 Specialty _____
 DEA _____
 NPI _____
 Address _____
 City _____
 State _____ ZIP _____
 Phone _____ Fax _____
 Pharmacy name _____
 NCPDP _____
 NPI _____
 Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Drug Name: _____

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill

Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Request for a Lower Co-pay (Tiering Exception) Criteria

- Please provide medical justification for a lower co-pay (tiering exception) for a formulary Nonpreferred Brand (Tier 3) drug.
 - All of the Preferred Brand (Tier 2) drugs for treatment of the same condition (check applicable statements and provide justification):
 - All formulary Tier 2 agents would not be effective
 - All formulary Tier 2 agents would have adverse effects
 - Patient preference for Tier 3 drug (Tier 2 agent may be effective)

Medical Justification: Provide clinical information or other evidence to support medical necessity for this request. List previous drugs and doses attempted for this patient, condition and dates or approximate dates or duration of treatment (if known). Document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. Attach additional pages if necessary. _____

DRUG NAME & DOSE	REASON FOR D/C	DURATION OF THERAPY

Prescriber's signature: _____ Date: _____