



Part D Coverage Determination Form Instructions And Redetermination Instructions

When we make a coverage determination, we are making a decision whether or not to provide coverage or pay for a Part D drug, and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an “exception” if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower copayment. If you request an exception, your physician must provide a statement to support your request. By law, certain types of drugs or categories of drugs are not covered by Medicare Part D Drug Plans and are not subject to this process. These drugs or categories of drugs are called “exclusions” and include:

- Non-prescription drugs
- Drugs when used for anorexia, weight loss, or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates (ex. Phenobarbital, Seconal)
- Benzodiazepines (ex. Xanax, valium)

If your doctor or pharmacist tells you that the Plan will not cover a prescription drug (other than those listed above), you should contact us and ask for a coverage determination. Examples of when you may want to ask us for a coverage determination are listed in Section 10 of your Evidence of Coverage (EOC). The following form may be used to request a coverage determination. We will contact the provider you listed on the form to obtain additional information. Please complete the form and return it to Mercy Health Plans. You may reference your EOC for other submission options, or simply fax it to:

Joplin PPO, St. Louis HMO and PPO members
314-214-8201 or 800-466-9854

Springfield HMO and PPO members
417-820-8167

If you have any questions or need further assistance, please contact Member Services, Monday through Friday, 8:00 a.m. to 5:00 p.m. (Central Time) at:

Joplin and Springfield PPO members

417-836-0429 or 1-866-875-0189; TDD 417-837-0249 or 1-800-446-1468

Springfield HMO members

417-837-0266 or 1-800-481-4466; TDD 417-837-0249 or 1-800-446-1468

St. Louis HMO members

314-214-8040 or 1-800-280-1602; TDD 314-214-8094 or 1-800-468-4418

St. Louis and Arkansas PPO members

314-810-8300 or 1-800-919-6459; TDD 314-214-8094 or 1-800-468-4418

You may also reach us via our website at: www.mercyhealthplans.com.

Redetermination Instructions

If you do not agree with the coverage determination, you can ask for a redetermination or appeal. You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you believe we should have reimbursed you more than you received, or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request, you may appeal.

You may file your redetermination or appeal by using the coverage determination form. Follow the Coverage Determination instructions, and in the box used to list the drug, please include the word "REDETERMINATION" with the drug information.

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 copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

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

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.