Gateway Health
Medicare Assured™

REQUEST FOR DRUG COVERAGE
FAX COMPLETED FORM TO: (888) 447-4369

Failure to complete this form in its entirety may result in an adverse coverage determination due to lack of information.

SECTION A – MEMBER INFORMATION			
First Name:	**Last Name:**	**Date of Birth:**	**Member ID:**
Allergies:	**Type of Reaction(s):**		

SECTION B – DRUG INFORMATION			
Drug Name:	**Dose & Frequency:**	**Quantity:**	**Length of Therapy:**
Associated Diagnosis:	☐ **New Prescription** ☐ **Existing Therapy**	**Date Initiated:**	**Was medication initiated in hospital?** ☐ **Yes** ☐ **No**

SECTION C – TYPE OF REQUEST

☐ Request for prior authorization for the prescribed drug.
☐ Request for step therapy for the prescribed drug.
☐ Request for an exception to existing criteria (prior authorization or step therapy exception).
☐ Request for a drug that is not on the list of covered drugs (formulary exception).
☐ Request for an exception to the limit on the number of doses (quantity limit exception).
☐ Request for a lower copayment (tiering exception).
☐ Other (please specify):

☐ **Request for Expedited Review:** By checking this box and signing below, I certify that applying the 72-hour review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

SECTION D – SUPPORTING STATEMENT

When requesting an exception, the prescribing physician **must** provide a supporting statement indicating why the requested prescription drug is medically necessary and formulary alternatives OR the number of doses available under a dose restriction have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction. **Please provide the supporting statement below and attach any additional supporting information (i.e. chart documentation).**

_____
_____
_____
_____
_____

SECTION E – FORMULARY ALTERNATIVES TRIED		
Drug Name/Strength:	**Dates Tried:**	**Reason therapy failed, discontinued, or contraindicated:**

SECTION F – PRESCRIBER INFORMATION		
Prescriber Name (printed):	**Specialty:**	**NPI Number:**
Office Phone:	**Office Fax:**	
Prescriber Signature:	**Date:**	

MAY PHOTOCOPY FOR OFFICE USE

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

If you need to speak to a Pharmacy Services Representative, call 1-800-685-5209 (PA), 1-888-447-4505 (OH), 1-855-847-6430 (NC), or 1-855-847-6380 (KY). Formulary information can be found at www.medicareassured.com.