



Comprehensive Care Management Corporation

A Member of the Beth Abraham Family of Health Services

Plan Name: Comprehensive Care Management

Phone #: 1-877-226-8500

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Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- Biotech or other specialty drugs for which drug-specific forms are required. See www.ccmny.org.

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID #:			NPI # (if available):		
Address:			Address:		
City:		State:	City:		State:
Home Phone:		Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle): M F	DOB:		Contact Person:		

Diagnosis and Medical Information				
Medication:		Strength and Route of Administration:		Frequency:
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:		Qty:
Height/Weight:	Drug Allergies:		Diagnosis:	
Prescriber's Signature:				Date:

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)
 → Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
 → Specify below: Anticipated significant adverse clinical outcome

Medical need for different dosage form and/or higher dosage
 → Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

Request for formulary tier exception
 → Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Other: _____ → Explain below

REQUIRED EXPLANATION: _____

Request for Expedited Review

REQUEST FOR EXPEDITED REVIEW [24 HOURS]
 → BY CHECKING THIS BOX AND SIGNING ABOVE, I 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 this form is protected health information and subject to all privacy and security regulations under HIPAA.