



**REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION**

This form may be sent to us by mail or fax:

Care Wisconsin Partnership  
 ATTN: Pharmacy Services  
 1617 Sherman Ave  
 Madison, WI 53704-5930

Fax Number  
 1-866-806-4134

You may also ask us for a coverage determination by phone at 1-800-963-0035 or through our website at: [www.carewisc.org/promptppa](http://www.carewisc.org/promptppa).

**Who May Make a Request:** Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

**Enrollee's Information**

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

**Complete the following section ONLY if the person making this request is not the enrollee or prescriber:**

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

**Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:**

**Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.**

**Name of prescription drug you are requesting** (if known, include strength and quantity requested per month):

- Generic substitution of this drug is acceptable.     The brand name of this drug is being requested.

**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 prior authorization for the drug my prescriber has prescribed.\*
- I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).\*
- 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 prescriber prescribed (formulary exception).\*
- My drug plan charges a higher copayment for the drug my prescriber 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).\*
- My drug plan charged me a higher copayment for a drug than it should have.
- 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 prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.**

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Additional information we should consider (*attach any supporting documents*):

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**Important Note: Expedited Decisions**

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

**CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

<b>Signature:</b>	<b>Date:</b>
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**Supporting Information for an Exception Request or Prior Authorization**

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

**REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

<b>Prescriber's Information</b>			
Name			
Address			
City	State	Zip Code	
Office Phone		Fax	
Prescriber's Signature			Date

<b>Diagnosis and Medical Information</b>			
Medication:	Strength and Route of Administration:		Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

**Rationale for Request**

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., 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)]
- Patient 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** \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

Care Wisconsin Medicare Dual Advantage and Care Wisconsin Partnership are HMO SNPs with a Medicare Advantage contract and a contract with the Wisconsin Department of Health Services for the Medicaid Program. Enrollment in Medicare Dual Advantage and Partnership depends on contract renewal.

This plan is available to anyone who has both Medical Assistance from the State and Medicare.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

This information is available for free in other languages or in an alternate format. Please call our customer service number from 8:00 AM to 8:00 PM Central / 7 days a week at 1-800-963-0035. TTY users should call Wisconsin Relay System 711.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.



### **Notice Informing Individuals About Nondiscrimination and Accessibility Requirements**

Care Wisconsin Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Care Wisconsin Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Care Wisconsin Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Rights.

If you believe that Care Wisconsin Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Care Wisconsin Member Rights  
1617 Sherman Ave  
Madison, WI 53704

Toll-Free Phone Number: 1-800-963-0035  
TTY: Wisconsin Relay System 711  
Fax: (608) 246-8428  
Email: [mrs@carewisc.org](mailto:mrs@carewisc.org)

If you need help filing a grievance, our Member Rights Specialists are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, DC 20201

Toll-Free Phone Number: 1-800-368-1019  
TDD: 800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index/html>



## Multi-Language Insert Multi-language Interpreter Services

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-963-0035 (TTY users should call Wisconsin Relay System 711).

### Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-963-0035 (TTY: 711).

### Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-963-0035 (TTY: 711).

### Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-963-0035 (TTY: 711)。

### German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-963-0035 (TTY: 711).

### Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1800-963-0035: هاتف الصم والبكم - (TTY: 711). (رقم

### Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-963-0035 (телетайп: 711).

### Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-963-0035 (TTY: 711)번으로 전화해 주십시오.

### Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-963-0035 (TTY: 711).

**Pennsylvanian Dutch**

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-963-0035 (TTY: 711).

**Laotian**

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-963-0035 (TTY: 711).

**French**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-963-0035 (TTY : 711).

**Polish**

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-963-0035 (TTY: 711).

**Hindi**

ध्यान दें • : य • द आप • हदी बोलते ह • तो आपके िलए मुफ्त म • भाषा सहायता सेवाएं उपलब्ध ह। •  
1-800-963-0035 (TTY: 711) पर कॉल कर • ।

**Albanian**

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-963-0035 (TTY: 711).

**Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-963-0035 (TTY: 711).