

**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.
- Visit [www.SilverScript.com](http://www.SilverScript.com) for a complete formulary listing.

**SECTION I: BENEFICIARY INFORMATION**

|                                       |                                      |
|---------------------------------------|--------------------------------------|
| LAST NAME, FIRST NAME (PLEASE PRINT)  | DOB (MM/DD/YYYY)                     |
| STREET ADDRESS                        | PHONE NUMBER (AREA CODE)             |
| CITY, STATE                           | ZIP CODE                             |
| SEX (circle)<br>M or F                | CARDHOLDER ID #                      |
| REQUESTOR'S NAME (IF NOT BENEFICIARY) | RELATIONSHIP TO BENEFICIARY*         |
| REQUESTOR'S STREET ADDRESS            | REQUESTOR'S PHONE NUMBER (AREA CODE) |
| REQUESTOR'S CITY, STATE               | REQUESTOR'S ZIP CODE                 |

\* YOU MUST ATTACH DOCUMENTATION THAT SHOWS AUTHORITY TO REPRESENT ENROLLEE

**SECTION II: PRESCRIBER INFORMATION**

|                                      |                          |
|--------------------------------------|--------------------------|
| LAST NAME, FIRST NAME (PLEASE PRINT) | PHONE NUMBER (AREA CODE) |
| STREET ADDRESS                       | FAX NUMBER (AREA CODE)   |
| CITY, STATE                          | NPI # (if available)     |
| ZIP CODE                             | OFFICE CONTACT PERSON    |

**SECTION III: PRESCRIPTION DRUG INFORMATION**

|                  |                     |
|------------------|---------------------|
| MEDICATION NAME  | MEDICATION STRENGTH |
| FREQUENCY OF USE | QUANTITY            |

**PLEASE COMPLETE REVERSE SIDE**

## Type of Coverage Determination

- 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 charged me a higher copayment for a drug than it should have.
- 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*):

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### **Request for Expedited Review**

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)

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Beneficiary/Requestor's Signature

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Date

Please complete the ENTIRE form and return in to the following address or fax number:

SilverScript Appeals Department – MC109, P.O. Box 52000, Phoenix, AZ 85072-2000, Fax: (866) 884-9475

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