NEW YORK STATE | Department of Civil Service
The Empire Plan

SilverScript Insurance Company
Empire Plan Medicare Rx
P.O. Box 52425, Phoenix, AZ 85072-2425

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form is used by SilverScript® Insurance Company, the administrator of Empire Plan Medicare Rx Prescription Drug Plan, for members to request a decision in regards to their prescription drug coverage. It may be sent to us by mail or fax (a copy of the form can also be found on our website at EmpirePlanRxProgram.com):

Address:
Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85072-2000

Fax:
1-855-633-7673

You may also ask us for a coverage determination by phone at 1-866-884-9479, 24 hours a day, 7 days a week. TTY users should call 711.

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 The Empire Plan at 1-877-769-7447 and select option 4 for the prescription drug program to learn how to name a representative, 24 hours a day, 7 days a week. TTY users should call 711.

Enrollee's Information:

Enrollee's Name: _____ Date of Birth: _____

Enrollee's Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Enrollee's Member ID #: _____

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

Requestor's Name: _____

Requestor's Relationship to Enrollee: _____

Requestor's Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Representation documentation for appeal 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) if it was not submitted at the coverage determination level. Contact The Empire Plan at 1-877-769-7447 (select option 4) to learn how to name a representative, 24 hours a day, 7 days a week. TTY users should call 711. For more information on appointing a representative, contact your plan or 1-800-MEDICARE (1-800-633-4227).

Prescription drug you are requesting:

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? ☐ Yes ☐ No

If "Yes":

Date purchased: _____ Amount paid: $_____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

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.

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

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.**

Signature of person requesting the coverage determination (the enrollee, or the enrollee's prescriber or representative):

_____ Date: _____

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.**

Prescriber's Information:

Name: _____

Address: _____

City _____ State _____ Zip Code: _____

Office Phone: _____ Fax: _____

Prescriber's Signature _____

Date _____

Diagnosis and Medical Information		
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:_____

_____

_____

_____

_____

_____

Your privacy is important to us. SilverScript employees are trained regarding the appropriate way to handle your private health information.

This information is available for free in other languages. Please call The Empire Plan at 1-877-769-7447 and select option 4 for the prescription drug program (TTY: 711), 24 hours a day, 7 days a week. Esta información está disponible gratuitamente en otros idiomas. Llame a Empire Plan al 1-877-769-7447 y seleccione la opción 4 para el programa de medicamentos recetados (teléfono de texto (TTY): 711), las 24 horas del día, los 7 días de la semana.

Empire Plan Medicare Rx is an Employer Prescription Drug Plan (PDP). This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.