Request for Prescription Information or Change
Medicare Prescription Drug Coverage
Provider Communication Form

TO: (Prescribing Physician):_________________________________________ Date:________________
Fax:_________________________________________ Phone:_________________________________

Patient Name:________________________________________________________________________
Name of Drug Plan:____________________________ Phone (if available):______________________
Member Number:______________________________ Prescription Number :_____________________

PRESCRIPTION ISSUES
☐ The patient’s drug plan has indicated that it will not pay for ___________________________________
                                             _______________________________________ for this patient because:
☐ Prior authorization required
☐ Step therapy required. Plan will pay for ___________________________________________
☐ Plan only authorizes____________________ dosage units (tablets/capsules) per prescription
☐ Plan does not pay for drug in dosage/format prescribed
☐ Drug is not on the formulary. NOTE:
☐ Plan authorized one-time only payment for this drug
☐ Plan did not authorize one-time payment
☐ Other drugs on the formulary include (if available): ___________________________
                                           ___________________________________________
☐ Other reason(s)____________________________________________________________________
☐ The patient’s drug plan covers this drug, but with a high tiered co-pay. Preferred drugs available at
lower co-pay: ______________________________________________________________________

☐ ACTION REQUESTED – Please Respond To Pharmacy:
Pharmacist Requesting Action:___________________________________________________________
☐ Urgent - patient is waiting
☐ By next refill:_________________________ (Date)
☐ Provide alternative medication:_________________________________________________________
☐ Other recommended action:___________________________________________________________

For Fax Back:
Physician Signature:_________________________________________ Date:________________

☐ ACTION REQUESTED – Please Contact Drug Plan:
☐ Request prior authorization
☐ Request exception to formulary

☐ INFORMATION ONLY - No Immediate Action Necessary

PLEASE NOTE: Medicare Part D does not pay for barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

FROM: Pharmacy Name:_______________________________________________________________
Fax:_____________________ Phone:_____________________ e-mail:__________________________
Address:________________________________________________________ Phone: ______________

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.
Use of this form is endorsed by the Alzheimer’s Association, American Medical Association, American Pharmacists Association, Center for Medicare Advocacy, Medical Group Management Association, National Community Pharmacists Association and the National Council on the Aging