Magellan COMPLETE CARE

Magellan Complete Care of Virginia (HMO SNP)
PRESCRIPTION DRUG COVERAGE DETERMINATION FORM
Copies of this form and additional information available at http://www.mccofva.com/dsnp

THIS FORM MAY BE SENT TO US BY MAIL OR BY FAX

Address: 58 Charles Street Cambridge, MA 02141 **Fax**: 1-888-251-7823

You may also ask for a coverage determination by phone at **1-855-818-4876**. **To avoid unnecessary delays, PLEASE ENSURE THAT YOU COMPLETE THE FORM IN ITS ENTIRETY AND PRINT NEATLY. Who May Make a Request:** The member and prescriber (on your behalf) may ask us for a coverage determination. If another individual (such as a family member or friend) makes a request for you, that individual must be your authorized representative. Contact us to learn how to name an authorized representative.

REQUESTING PARTY: ☐ PRESCRIBER ☐ MEMBER ☐ MEMBER'S AUTHORIZED REPRESENTATIVE

*Please note that a member's authorized representative must have adequate documentation on file, such as an active Appointment of Representative Form (AOR Form), to avoid delays.

ENROLLEE INFORMATION

Member's Name:	**Member Authorized Representative Name (if applicable):**	**Date of Birth:**
Weight:	**Height:**	**SWH Member ID #:**

DRUG BEING PRESCRIBED

Select one: Generic substitution authorized ☐ **Dispense as written** ☐

Name of Drug:	**Strength:**	**Quantity Per 30 Days:**
Route:	**Directions:**	**Duration of Therapy:**

PRESCRIBER INFORMATION

Name:	**Specialty:**	**Office Contact:**
Address:	**City:**	**State:**
Office Phone:	**Fax:**	**NPI:**

RATIONALE FOR REQUEST

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change**
☐ **Medical need for different dosage form and/or higher dosage**

Rationale for need for a formulary non-preferred product / non-formulary product	**Current relevant diagnosis:**
Please provide:	**Please provide ICD-10 and description:**
Relevant lab results, scans, x-rays, etc., that support use of therapy (Please attach copy of most recent labs).	**Drug Allergies**
Please provide:	**Please Provide:**

Please list alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity,

allergy, or therapeutic failure.

Drug & Dose	Route	Frequency	Start Date	Stop Date	Outcome/Reason for failure

IMPORTANT:
Please provide additional relevant clinical information that will help us to facilitate processing of your request:

HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY

If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ **YES** ☐ **NO**

OPIOIDS – (please complete the following questions if the requested drug is an opioid)

What is the daily cumulative Morphine Equivalent Dose **(MED)**? **mg/day**

Are you aware of other opioid prescribers for this enrollee? ☐ **YES** ☐ **NO**
If so, please explain.

Is the stated daily MED dose noted medically necessary? ☐ **YES** ☐ **NO**
Would a lower total daily MED dose be insufficient to control the enrollee's pain? ☐ **YES** ☐ **NO**

URGENT REQUEST CHECK ☐	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 physician 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.

Signature:	**Date:**