MOLINA HEALTHCARE
Your Extended Family.

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

Address:	Fax Number:
7050 S Union Park Center Drive Suite 200 Midvale, Utah 84047	(866) 290-1309

You may also ask us for a coverage determination by phone at (866) 856-8699 or through our website at MolinaHealthcare.com/Duals.

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):

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:	**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** _____ _____ _____ _____ _____

Molina Dual Options STAR+PLUS MMPis a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

You can get this document for free in other formats, such as large print, braille, or audio. Call (866) 856-8699, TTY/TDD: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. The call is free.

Molina Healthcare of Texas (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language
  - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (866) 856-8699; TTY/TDD: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (562) 499-0610.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

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

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. If you need help, call 1-800-368-1019; TTY 800-537-7697.

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English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-856-8699 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-856-8699 (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 1-866-856-8699（TTY：711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-856-8699 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-856-8699 (ATS : 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-856-8699 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-856-8699 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-856-8699 (TTY: 711) 번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-856-8699 (телетайп: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-856-8699 (رقم هاتف الصم والبكم: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-856-8699 (TTY: 711) पर कॉल करें।

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-856-8699 (TTY: 711).

Portugués

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-856-8699 (TTY: 711).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-856-8699 (TTY: 711).

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-856-8699 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-856-8699（TTY: 711）まで、お電話にてご連絡ください。

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-856-8699 (TTY: 711) تماس بگیرید.

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-856-8699 (TTY: 711).

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບ ່ ເສັຽຄ່າ, ແມ່ນພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-856-8699 (TTY: 711).

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-866-856-8699 (TTY: 711)