MeridianComplete
(Medicare-Medicaid Plan)

meridiancomplete

REQUEST FOR MEDICARE DRUG COVERAGE DETERMINATION

Use this form to ask our plan for a coverage determination. You can also ask for a coverage determination by phone at 1-855-323-4578, TTY: 711. Or through our website at mmp.MImeridian.com. You, your doctor or prescriber, or your authorized representative can make this request. If you have questions, please call your Care Coordinator at 1-855-323-4578 (TTY: 711). Hours are 8 a.m. to 5 p.m., Monday through Friday. After hours, on weekends, and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Or, you can call Member Services at 1-855-323-4578 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Plan Enrollee

Name	Date of birth
Street address	City
State	ZIP
Phone	Member ID #

If the person making this request isn't the plan enrollee or prescriber:

Requestor's name
Relationship to plan enrollee
Street address (include City, State and ZIP)
Phone
☐ Submit documentation with this form showing your authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or equivalent). For more information on appointing a representative, contact our plan or call 1-800-MEDICARE. (1-800-633-4227). TTY users can call 1-877-486-2048.

Name of drug this request is about (include dosage and quantity information if available)

Type of Request

☐ My drug plan charged me a higher copayment for a drug than it should have

☐ I want to be reimbursed for a covered drug I already paid for out of pocket

☐ I'm asking for prior authorization for a prescribed drug (this request may require supporting information)

For the types of requests listed below, your prescriber MUST provide a statement supporting the request. Your prescriber can complete pages 3 and 4 of this form, "Supporting Information for an Exception Request or Prior Authorization."

☐I need a drug that's not on the plan's list of covered drugs (formulary exception)

☐ I've been using a drug that was on the plan's list of covered drugs before, but has been or will be removed during the plan year (formulary exception)

☐ I'm asking for an exception to the requirement that I try another drug before I get a prescribed drug (formulary exception)

☐ I'm asking for an exception to the plan's limit on the number of pills (quantity limit) I can get so that I can get the number of pills prescribed to me (formulary exception)

☐ I'm asking for an exception to the plan's prior authorization rules that must be met before I get a prescribed drug (formulary exception).

☐ My drug plan charges a higher copayment for a prescribed drug than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception)

☐ I've been using a drug that was on a lower copayment tier before, but has or will be moved to a higher copayment tier (tiering exception)

Additional information we should consider *(submit any supporting documents with this form)*:

_____
_____
_____
_____

Do you need an expedited decision?

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'll automatically give you a decision within 24 hours. If you don't get your prescriber's support for an expedited request, we'll decide if your case requires a fast decision. (You can't ask for an expedited decision if you're asking us to pay you back for a drug you already received.)

☐ **YES, I need a decision within 24 hours.** If you have a supporting statement from your prescriber, attach it to this request.

Signature:	**Date:**

How to submit this form

Submit this form and any supporting information by mail or fax:

Address:
Medicare Pharmacy Prior Authorization Department
P.O. Box 31397
Tampa, FL 33631-3397

Fax Number:
1-877-941-0480

Supporting Information for an Exception Request or Prior Authorization
To be completed by the prescriber

☐ **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 Information

Name
Street Address (Include City, State and ZIP)
Office phone
Fax
Signature Date

Diagnosis and Medical Information

Medication:	Strength and route of administration:
Frequency:	Date started: ☐ **NEW START**
Expected length of therapy:	Quantity per 30 days:
Height/Weight:	Drug allergies:

DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes **(**If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)	**ICD-10 Code(s)**
Other RELEVANT DIAGNOSES:	**ICD-10 Code(s)**

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY		
Any **FDA NOTED CONTRAINDICATIONS** to the requested drug?	☐ **YES**	☐ **NO**
Any concern for a **DRUG INTERACTION** when adding the requested drug to the enrollee's current drug regimen?	☐ **YES**	☐ **NO**
If the answer to either of the questions above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety		
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 – (answer these 4 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? If so, please explain.	☐ **YES**	☐ **NO**
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**

RATIONALE FOR REQUEST

☐ **Alternate drug(s) previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure.** If not noted in the DRUG HISTORY section, specify below: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed.

☐ **Alternative drug(s) contraindicated, would not be as effective or likely to cause adverse outcome.** A specific explanation why alternative drug(s) would not be as effective or anticipated significant adverse clinical outcome and why this outcome would be expected is required. If contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated.

☐ **Patient would suffer adverse effects if he or she were required to satisfy the prior authorization requirement.** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required.

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐ **Medical need for different dosage form and/or higher dosage** Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists.

☐ **Request for formulary tier exception** If not noted in the DRUG HISTORY section, specify below: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated.

☐ **Other** (explain below)

_____

_____

_____

_____

MeridianComplete (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Michigan 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 1-855-323-4578 (TTY: 711), 8 a.m. to 8 p.m., seven days a week. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

Multi-Language Insert
Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter, just call us at 1-855-323-4578 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Someone who speaks English/Language can help you. This is a free service.

Spanish: Contamos con los servicios gratuitos de un intérprete para responder las preguntas que tenga sobre nuestro plan de salud o de medicamentos. Para solicitar un intérprete, simplemente llámenos al 1-855-323-4578 (TTY: 711). El horario de atención es de 8 a.m. a 8 p.m, los siete días de la semana. Los fines de semana y los días festivos estatales o federales, es posible que se le pida que deje un mensaje. Se le devolverá la llamada al siguiente día hábil. Alguien que hable español puede ayudarlo. Este es un servicio gratuito.

Chinese (Cantonese): 我們提供免費的口譯服務，可解答您對我們的健康或藥物計劃可能有的任何疑問。如需口譯員服務，您僅需於每週七天上午 8 點至晚上 8 點致電 1-855-323-4578 (TTY：711) 與我們聯絡。週末及州或聯邦假日，可能會要求您留言。我們將在下一個工作日內回電給您。會說中文的人員可以幫助您。此為免費服務。

Chinese (Mandarin): 我们提供免费口译服务，可解答您对我们的健康或药物计划的有关疑问。要获得口译服务，请于周一至周日上午 **8** 点至晚上 **8** 点致电 **1-855-323-4578**（**TTY**：**711**）。在周末及州或联邦假日，您可能需要留言。您的来电将在下一个工作日内得到回复。您将获得中文普通话口译员的帮助，而且这是一项免费服务。

Tagalog: May mga libre kaming serbisyo ng interpreter para sagutin ang anumang posible ninyong tanong tungkol sa aming planong pangkalusugan o plano sa gamot. Upang makakuha ng interpreter, tumawag lang sa amin sa 1-855-323-4578 (TTY: 711) mula 8 a.m. hanggang 8 p.m., Lunes hanggang Biyernes. Para sa mga oras pagkatapos ng trabaho, Sabado at Linggo, at pista opisyal, maaaring magpaiwan sa inyo ng mensahe. May tatawag sa inyo sa susunod na araw na may pasok. May makakatulong sa inyo na nagsasalita ng Tagalog. Isa itong libreng serbisyo.

French: Nous proposons des services d'interprètes gratuits pour répondre à toutes vos questions sur notre régime de santé ou de médicaments. Pour obtenir les services d'un interprète, appelez-nous au 1-855-323-4578 (TTY : 711) tous les jours, de 8 h à 20 h. Si vous appelez pendant les week-ends et jours fériés, vous devrez peut-être laisser un message. Nous prendrons alors votre appel en compte le jour ouvrable suivant. Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào về chương trình sức khỏe hoặc chương trình thuốc của chúng tôi. Để nhận thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-855-323-4578 (TTY: 711), từ 8 a.m. đến 8 p.m., bảy ngày một tuần. Vào các ngày cuối tuần và ngày lễ của tiểu bang hoặc liên bang, quý vị có thể được yêu cầu để lại tin nhắn. Sẽ có người phản hồi cuộc gọi của quý vị vào ngày làm việc tiếp theo. Một nhân viên nói tiếng Việt có thể giúp quý vị. Dịch vụ này miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetschservice, wenn Sie Fragen zu unseren Gesundheits- oder Medikamentenplänen haben. Um einen Dolmetscher in Anspruch zu nehmen, rufen Sie uns von Montag bis Freitag zwischen 8 und 20 Uhr unter folgender Telefonnummer an: 1-855-323-4578 (TTY: 711). Außerhalb der Geschäftszeiten, an Wochenenden und an Feiertagen werden Sie möglicherweise aufgefordert, eine Nachricht zu hinterlassen. Wir rufen Sie am nächsten Werktag zurück. Ein deutschsprachiger Mitarbeiter wird Ihnen behilflich sein. Dieser Service ist kostenlos.

Korean: 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우 주 7일, 오전 8시부터 오후 8시까지 1-855-323-4578(TTY: 711)번으로 당사에 연락해 주십시오. 주말 및 공휴일에는 메시지를 남겨 주시면 됩니다. 그러면 다음 영업일에 전화드리겠습니다. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

Russian: Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, вам доступны бесплатные услуги переводчика. Если вам нужен переводчик, просто позвоните нам по номеру 1-855-323-4578 (TTY: 711). Часы работы: с 8 a.m. до 8 p.m. без выходных. В выходные и праздничные дни федерального уровня или на уровне штата вас могут попросить оставить сообщение. Вам перезвонят на следующий рабочий день. Вам окажет помощь сотрудник, говорящий на русском языке. Данная услуга бесплатна.

Arabic: وفّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، يرجى الاتصال بنا على الرقم 1-855-323-4578 (TTY: 711) طوال أيام الأسبوع من الساعة 8 صباحًا لغاية الساعة 8 مساءً. قد يُطلب منك ترك رسالة في عطلات نهاية الأسبوع وخلال الإجازات الوطنية والفيدرالية وسنعاود الاتصال بك خلال يوم العمل التالي. يمكن أن يساعدك شخص يتحدث العربية. وتتوفر هذه الخدمة بشكل مجاني.

Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il numero 1-855-323-4578 (TTY: 711) dalle 8:00 alle 20:00, sette giorni a settimana. Nei fine settimana e nei giorni festivi potrebbe essere necessario lasciare un messaggio. La ricontatteremo entro il giorno lavorativo successivo. Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número 1-855-323-4578 (TTY: 711). O serviço está disponível sete dias por semana, das 8:00 às 20:00. Se ligar ao fim de semana ou num feriado estadual ou federal, poderá ter de deixar mensagem. A sua chamada será devolvida no próximo dia útil. Um falante de português poderá ajudá-lo. Este serviço é gratuito.

**French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, senpleman rele nou nan 1-855-323-4578 (TTY: 711). Lè biwo yo se soti 8è a.m. rive 8è p.m., sèt jou pa semèn. Nan wikenn ak pandan jou ferye eta oswa federal yo, yo gendwa mande w pou ou kite yon mesaj. Y ap rele w pwochen jou biwo yo louvri a. Yon moun ki pale Kreyòl Ayisyen kapab ede w.
Se yon sèvis gratis.**

Polish: Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod numer 1-855-323-4578 (TTY: 711) w godzinach od 8:00 do 20:00, siedem dni w tygodniu. Po godzinach pracy, w weekendy i święta konieczne może być pozostawienie wiadomości. Oddzwonimy w następnym dniu roboczym. Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

Hindi: हमारे स्वास्थ्य या ड्रग प्लान के बारे में आपके किसी भी सवाल का जवाब देने के लिए, हम मुफ़्त में दुभाषिया सेवाएं देते हैं। दुभाषिया सेवा पाने के लिए बस हमें 1-855-323-4578 (TTY: 711) पर कॉल करें। कॉल करने का समय सप्ताह के सातों दिन सुबह 8 बजे से रात 8 बजे तक है। सप्ताहांत और राज्य या संघीय छुट्टियों पर, आपसे एक संदेश छोड़ने के लिए कहा जा सकता है। अगले कार्य दिवस पर आपके कॉल का जवाब दिया जाएगा। हिंदी बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Japanese: 弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、月曜日～金曜日の午前 8 時～午後 8 時に、1-855-323-4578（TTY：711）までお電話ください。週末や祝日は、留守番電話にメッセージを残す必要がある場合があります。その場合は、折り返しお電話いたします。日本語の通訳担当者が対応します。これは無料のサービスです。

Albanian: Ne ofrojmë shërbime interpretimi pa pagesë për t'iu përgjigjur çdo pytjeje që mund të keni lidhur me planin tonë për shëndetin ose për barnat. Për t'u lidhur me një interpret, thjesht na telefononi në numrin 1-855-323-4578 (TTY: 711), nga ora 8:00 deri në 20:00, nga e hëna në të premte. Gjatë fundjavave dhe festave, mund t'ju kërkohet të lini një mesazh. Telefonata do t'ju kthehet brenda ditës së ardhshme të punës. Dikush që flet shqip mund t'ju ndihmojë. Ky është një shërbim pa pagesë.

Assyrian: ܐܝܬ ܠܢ ܬܘܪܓܡܢܘܬܐ ܕܡܓܢ ܚܕܡܬܐ ܡܚܘܝܢܬܐ ܠܟܠܚܘܢ ܫܘܐܠܐ ܥܠ ܚܕ ܒܣܘܡܐ ܕܐܝܬ ܠܘܟܘܢ ܒܗ̈ ܚܘܠܡܢܐ ܕܕܪ̈ܡܢܐ ܘܬܘܠܦܢܐ ܕܝܢ. ܠܫܡܥܐ ܟܠܗ ܚܕܐ ܡܢܐ ܟܘܢ ܠܢ ܒ 1-855-323-4578 (TTY: 711)ܡܢ 8 ܩܕܡܬܐ ܗܠ 8 ܒܪܡܫܐ، ܬܪܝܢܒܫܒܐ ܗܠ ܥܪܘܒܬܐ. ܐܢ ܦܢܝܬܘܢ ܟܠܐ ܐܘܪܐ ܫܒܬܐ ܐܘ ܒܥܐܕܢܐ ܕܒܠܕܝܬܐ ܥܘܡܐ ܕܩܐܫ ܡܠܟܘܬܐ ܡܘܟܠܘܢ ܕܫܒܩܬܘܢ ܐ ܒܪܬܐ، ܘܐܬܝܐܬܐ ܒܕ ܦܢܝ ܠܘܟܘܢ ܒܝ̈ܘܡܐ ܕܒܬܪ ܗܘܢܬܐ ܒܕ ܡܫܪܝܢܘܢ. ܐܢܫܐ ܬܫܡܫܬܐ ܡܓܢܝܬܐ ܝܠܗ.

Bengali: আমাদের স্বাস্থ্য বা ড্রাগ বিষয়ক পরিকল্পনা সম্পর্কে আপনার যে কোনও প্রশ্নের উত্তর দিতে আমরা বিনামূল্যে দোভাষীর পরিষেবা দিই। দোভাষীর পরিষেবা পেতে কেবল আমাদের 1-855-323-4578 (TTY: 711) নম্বরে কল করুন। সময় হ'ল সপ্তাহের সাত দিনই সকাল 8টা থেকে রাত্রি 8টা। সপ্তাহান্তে এবং প্রদেশ বা কেন্দ্রীয় ছুটির দিনগুলিতে আপনাকে একটি মেসেজ দিয়ে রাখতে বলা হতে পারে। আপনাকে পরবর্তী কাজের দিন কল করা হবে। বাংলা বলতে পারেন এমন কেউ আপনাকে সাহায্য করতে পারেন। এই পরিষেবাটি বিনামূল্যে।

Serbo-Croatian: Nudimo besplatne usluge tumača koji će odgovoriti na sva pitanja koja potencijalno imate o svom zdravlju i planu lekova. Da biste dobili tumača treba samo da nas pozovete na broj 1-855-323-4578 (TTY: 711). Radno vreme je od 08:00 do 20:00, sedam dana u nedelji. Tokom vikenda, državnih i nacionalnih praznika možemo tražiti od vas da ostavite poruku. Poziv ćete primiti u toku narednog radnog dana. Neko ko govori srpskohrvatski jezik će vam pomoći. Usluga je besplatna.