

**OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD**



**COVERAGE DETERMINATION REQUEST  
COMPLETED BY PHYSICIAN**

The following drugs are not covered: 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).

<b>Member's Information</b>		
		/ /
Name	Date of Birth	HealthChoice ID Number
Member's Address	City	State Zip Code
( )		
Phone		
<b>Representative's Information</b>		
Representative's Name (if not enrollee)		
Representative's relationship to member (if other than prescribing physician, attach documentation showing the authority to represent the member)		
<b>Prescription Information</b>		
Drug Name	Strength	Quantity and Quantity Requested Per Month
<b>Prescribing Physician's Information</b>		
Name	Medical Specialty	
Address	City	State Zip Code
( )	( )	
Office Phone	Fax	Contact Person

## What Type of Coverage Determination Do You Want to Request?

- My patient needs a drug that is not on the HealthChoice Medicare Formulary. I want to request a formulary exception for my patient.
- A drug that my patient is taking is being removed from the HealthChoice Medicare Formulary. I am requesting a formulary exception for my patient to receive continued coverage for the drug.
- I am requesting a formulary exception to the requirement that my patient try another drug before HealthChoice will pay for the drug that I have prescribed.
- I am requesting a prior authorization for a drug that I have prescribed for my patient.
- I disagree with the plan's limit on the number of pills my patient can receive (quantity limitation). I am requesting a formulary exception so my patient can receive the number of pills I have prescribed.
- HealthChoice charges a higher copayment for the drug I prescribed for my patient than it charges for another drug that treats the same condition. I am requesting a tier exception for my patient to receive the medication at the lower copayment.
- A drug my patient is taking is moving to a higher copayment tier. I am requesting a tier exception for my patient to continue receiving the drug at the lower copayment.

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**\*NOTE: If you are asking for a formulary or tier exception for your patient, you must provide a letter of medical necessity to support your request.**

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Additional Information we should consider (attach any supporting documents)

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If you believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your patient's life or health or ability to regain maximum function, you can ask for an expedited (fast) decision by marking the box below. If you ask for a fast decision for your patient, we will give you a decision within 24 hours. If you do not submit supporting documentation, we will decide if your patient's health condition requires a fast decision.

- I need an expedited coverage determination (attach physician's supporting statement, if applicable)

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Prescribing Physician's Signature

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Date

**Return this request to Medco Health, Attention: Coverage Appeals 8111 Royal Ridge Parkway, Irving, TX 75063. Be aware that additional information may be requested. For additional information about requesting a coverage determination, see your HealthChoice Medicare Supplement Part D Plan handbook or log on to [www.healthchoiceok.com](http://www.healthchoiceok.com).**