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:_________________________ Plan Phone (if available):____________________
Member Number:_________________________ Prescription Number :_____________________

PRESCRIPTION ISSUES
☐ The patient’s drug plan has indicated that it will not pay for ___________________________________
☐ 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 higher tiered co-pay. Preferred drugs available at
lower co-pay (if available):

☐ 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 – Contact Drug Plan to Request ☐ prior authorization ☐ formulary exception

☐ 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:________________________________________________________

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

The Centers for Medicare & Medicaid Services has reviewed this fax form, but does not require its use. Use of the form
for communications between pharmacists and physicians is voluntary. It is not a legal document. The official Medicare
program provisions are contained in relevant laws, regulations, and rulings.