Universal Pharmacy Programs Request Form

This form can be used to request coverage for drug products that are restricted in some way under a pharmacy management program.

For Medicare Part B vs. Part D coverage determinations, go to thpmp.org/coverage-determination-b-vs-d for the criteria/request form.

To submit via mail, send to *Tufts Health Plan, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Pharmacy Utilization Management Department.*

THIS FORM CAN BE USED FOR THE FOLLOWING PLANS AND PRODUCTS:

Fax to 617.673.0956:

- ☐ Tufts Medicare Preferred HMO
- ☐ Tufts Health Plan Senior Care Options (SCO)
- ☐ Tufts Health Unify

PATIENT INFORMATION

Name:_____

Member ID:_____

Date of Birth: _____

Diagnosis: _____

PRESCRIBER INFORMATION

Name: _____

NPI:_____ DEA/xDEA:_____

Phone: _____ Fax: _____

Office Contact: _____ Specialty:_____

REQUESTED DRUG

Name and strength: _____

Select one: ☐ Generic substitution authorized ☐ Dispense as written (DAW)

Dosage form: _____ Route of Administration:_____ Requested Quantity:_____

Will the drug be supplied by and administered in the Provider's office (i.e., Buy & Bill)? ☐ Yes ☐ No

CLINICAL JUSTIFICATION FOR REQUEST (if applicable)

Prior Medications	Adverse Reaction	Treatment Failure	Length of Therapy
	☐	☐	
	☐	☐	
	☐	☐	

EXPLANATION: Describe adverse reaction, treatment failure, or significant adverse clinical outcomes in detail. If not as effective, length of therapy on each drug and outcome.

(attach separate sheet if needed)

THIS SECTION APPLIES TO TUFTS MEDICARE PREFERRED HMO, TUFTS HEALTH PLAN SENIOR CARE OPTIONS and TUFTS HEALTH UNIFY only.

Does the member's condition require expedited review [24 hours]? ☐ **Yes*** ☐ **No**

*By checking this box **and signing**, I certify that the 72-hour standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Does this member reside in long-term care? ☐ **Yes** ☐ **No**

Is the member enrolled in Hospice? ☐ **Yes** ☐ **No** If no, disenrollment date: _____

Is the drug related to the terminal illness or related conditions? ☐ Yes ☐ No

Provide an explanation of why the drug being prescribed is unrelated to the terminal illness/related conditions:

_____

_____

Is this a request for a formulary tier exception (the member's drug plan charges a higher copayment for the drug prescribed than it charges for another drug that treats the condition, and I want to pay the lower copayment – excludes nonformulary drugs and drugs on the specialty tier)*? ☐ Yes* ☐ No

*If yes, a supporting statement from the prescribing physician is required. Please specify the request: (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

Prescriber Signature (required):_____ **Date:**_____

By signing this form, I attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by Tufts Health Plan.

Provider Services
Provider Relations