CenCal CareConnect

CenCal HEALTH
Local. Quality. Healthcare.

Part D Request for Supporting Statement

The patient named below has requested a **Formulary Exception or Tiering Exception** *from CenCal CareConnect (HMO D-SNP). Please review the criteria below and select* (1), (2), and/or (3) if applicable. You may also provide this information by **calling 1-877-814-1861 (TTY: CA Relay at 711)**, 7 days a week, 8 a.m. to 8 p.m. PT. **Please sign and FAX THIS FORM TO:** CenCal CareConnect Fax: **1-805-681-3009**. If you have questions, call 1-877-814-1861.

Member Name (Last, First, Middle Initial) _____

CenCal CareConnect Member ID Number _____

Date of Birth _____

Name of Medication in Dispute _____

Formulary Exception Criteria (Per §40.5.3):

The requested drug is medically necessary for one of the following reasons:

☐ 1. All covered Part D drugs on any tier of the plan's formulary would not be as effective for the member as the requested non-formulary drug, and/or would have adverse effects;

☐ 2. The number of doses available under a dose restriction for the requested drug:

a. Has been ineffective in the treatment of the member's disease or medical condition; or

Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; **and/or**

☐ 3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:

b. Has been ineffective in the treatment of the member's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the member.

Tiering Exception Criteria (Per §40.5.3):

The drug(s) in the applicable lower cost-sharing tier(s) for the treatment of the member's condition would:

☐ 1. Not be as effective as the requested drug; and/or

☐ 2. Have adverse effects

Please provide any additional information you deem relevant below:

Date _____

Signature of Provider _____