

**REQUEST FOR PRESCRIPTION DRUG COVERAGE**

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations). **Use of this form is not required. Please call PrimeTime Health Plan Customer Service at 330-363-7407 or 1-800-577-5084, TTY: (330) 580-6460 or (800) 617-7446 for additional information.**

**Enrollee's/Requestors Information:**

_____	_____
Enrollee's Name	Enrollee's Date of Birth
_____	_____
Enrollee's ID or Social Security Number	Enrollee's Group Number

**Prescription Medication Information:**

\_\_\_\_\_  
Name of medication (please include strength, doses per day, if known)

**Prescribing Physician's Information:**

_____	_____
Name of Physician	Phone number for Physician

**Type of Coverage Determination Request**

- I need a drug that is not covered on PrimeTime's Formulary
- I have been using a drug that was previously on the formulary but has been removed
- I request an exception to PrimeTime Plan's limit on the number of pills I can receive
- I request prior authorization for the drug my physician has prescribed
- I use a drug that has higher co-pay than other drugs that treat my condition or my medication has been moved to a higher tier and I want to pay the lower co-payment (You cannot obtain a brand name drug at the generic co-pay).

Please note, these requests may require supporting documentation from the physician, if so we will contact the physician to request the information. **A decision will be rendered within 72 hours of receipt of all information. If you feel waiting 72 will harm your life/health please contact PrimeTime Health Plan immediately to request an expedited determination.**

_____	_____
Enrollee/Requestors Signature (if other than enrollee please specify relationship)	Date

**Mail Completed Form to PrimeTime Health Plan P.O. Box 6905 Canton, Ohio 44710**