

1199SEIU Benefit Funds

498 Seventh Avenue, 9th Floor, New York, NY 10018-0009 • Tel: (646) 473-7446 • Fax: (646) 473-7469 • www.1199SEIUBenefits.org •   @1199SEIUBenefits

1199SEIU 90-DAY RX SOLUTION MAINTENANCE DRUG ACCESS PROGRAM WAIVER REQUEST FORM

Please print clearly in blue or black ink, or complete online.

The 1199SEIU Benefit Funds requires the following information to review a request to waive the 1199SEIU 90-Day Rx Solution Maintenance Drug Access Program for patients in a nursing home, assisted living facility or residential treatment facility.

REQUEST SUBMITTED BY _____

REQUEST DATE (MM/DD/YYYY) _____

PATIENT INFORMATION

MEMBER'S FULL NAME _____

MEMBER ID # _____

PATIENT'S FULL NAME (IF NOT THE MEMBER) _____

PATIENT'S DATE OF BIRTH (MM/DD/YYYY) _____

Does the patient reside at home? No Yes

Is the patient a resident of a nursing home, assisted living facility or residential treatment facility? No Yes

If "Yes," what date did the patient become a resident of the nursing home or long-term care facility? _____
(MM/DD/YYYY)

Will the patient be released from the nursing home or long-term care facility? No Yes

If "Yes," what is the patient's expected release date from the nursing home or long-term care facility? _____
(MM/DD/YYYY)

Does the nursing home or long-term care facility require blister-packed medications? No Yes

Does the nursing home's or long-term care facility's pharmacy blister-pack medications for residents? No Yes

Does the nursing home's or long-term care facility's pharmacy participate in the Express Scripts retail pharmacy network? No Yes

What is the effective date of the waiver? _____
(MM/DD/YYYY)

Provide explanation why the waiver is being requested: _____

Is the patient enrolled in Medicare Part A and Part B? No Yes

If "Yes," what is the effective date? Part A: _____ Part B: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Is the patient enrolled in Medicare Part D? No Yes

If "Yes," what is the effective date? _____
(MM/DD/YYYY)

Is the patient enrolled in Medicaid? No Yes

If "Yes," what is the effective date? _____
(MM/DD/YYYY)

If applicable, provide information for the patient's designated Power of Attorney:

POWER OF ATTORNEY'S NAME _____ TELEPHONE _____

Provide information on the pharmacy providing blister-packed prescriptions for the nursing home or long-term care facility:

PHARMACY NAME _____ NPI# _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____

List all of the patient's prescription medications (include name, dosage and frequency):

NURSING HOME / LONG-TERM CARE FACILITY INFORMATION

Type of facility (choose one): Nursing home Assisted living facility Residential treatment facility

NAME OF NURSING HOME OR LONG-TERM CARE FACILITY _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

X
AUTHORIZED FACILITY ADMINISTRATOR'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

PRINT NAME _____ TITLE _____

Fax completed form to:

(646) 473-7469

OR

Mail completed form to:

1199SEIU Benefit Funds
498 Seventh Avenue, 9th Floor
New York, NY 10018-0009
Attn: Benefits Administration-Pharmacy

Please refer to the Fund's website www.1199SEIUFunds.org to review the latest Preferred Drug List (PDL). Benefits are subject to each Fund's Summary Plan Description (SPD) and the discretion of the Trustees of that Fund.