# 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: _____ (MM/DD/YYYY) Part B: _____ (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

AF400 • 02/21 • 1199SEIU 90-DAY RX SOLUTION MAINTENANCE DRUG ACCESS PROGRAM WAIVER REQUEST FORM

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.