330 West 42nd Street • New York, NY 10036 • Phone: (646) 473-7446 • Fax: (646) 473-7469 • www.1199SEIUBenefits.org

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)

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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**

Mail completed form to:

1199SEIU Benefit Funds
330 West 42nd Street, 29th Floor
New York, NY 10036
Attn: Benefits Administration–Pharmacy

OR

Fax completed form to:

(646) 473-7469

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.

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