(Serve you.)

THE HAND-CRAFTED PBM

request for benefit change

PLEASE FILL OUT ELECTRONICALLY

INTERNAL USE ONLY CQ#:

Company Name: **City Of Manitowoc**
Effective Date of Change: / / Serve You Account Number: **3146**

☒ All Groups ☐ Group Number/Name:

Check each box for modifications to your benefit design to be effective on the above date.

Plan Design: ☐ 2 Tier ☐ 3 Tier ☐ Specialty Tier ☐

☐ **Copay Change to:**

Retail: Tier 1: Tier II: Tier III: Specialty Tier:

Mail: Tier 1: Tier II: Tier III: Specialty Tier:

☐ **Specialty Drug Coverage Change(s):**
- ☐ Restrict to DirectRx Mail Order Pharmacy – limit to 30 days supply – apply Specialty Tier copay
- ☐ Limit to 30 days supply – retail and mail order – open network – apply Specialty Tier copay
- ☐ Specialty Drug Split Fill Program

☒ **Drug Coverage Change(s) – inclusion/exclusion, quantity limitations, fill/benefit maximums, etc.**
- Implement Split Fill Specialty Program

☐ **Plan Design Change(s) – implement mandatory mail, change days supply, generic substitution rules, etc.**
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☐ **Clinical Programs:** ☐ **Implement the following** ☐ **Terminate the following**
- ☐ Adherence Monitoring Program
- ☐ Controlled Substance Monitoring Program
- ☐ Dose Optimization
- ☐ Generic Incentive Program ☐ $0 Copay ☐ $_____ Copay
- ☐ Quantity Limits
- ☐ Clinical Prior Authorizations
- ☐ Step Therapy Program ☐ *Apply grandfathering*

☐ **Other: Accumulators, deductibles, out of pocket maximum, benefit maximums (Indicate single/family, embedded, combined, etc.) and other changes not noted above.**
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CLIENT AUTHORIZATION

I authorize Serve You to make modification to our benefit design according to the specifications listed above. Any changes to the above information must be submitted to Serve You in writing, indicating the effective date of change.

Client Signature: _____ Date: / /
Title:
Phone: ( ) - Email:

SERVE YOU CONFIRMATION

Requested modifications to plan design have been completed and will be effective on date specified above.

Serve You Signature: _____ Date: / /

Upon completion of form and signed client authorization, please email, mail, or fax to:

EMAIL: clientservices@serve-you-rx.com

MAIL: Serve You
Attention: Client Services
10201 Innovation Drive, Suite 600
Milwaukee, WI 53226

FAX: 414-410-3230