Prior Authorization Form

Medicare Administrative Prior authorization for Part B/D coverage

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Date: ____________________ Patient ID #: ____________________ DOB: ______________

Patient Name: ____________________ Provider NPI: ____________________

Prescribing Physician: ____________________ Office Contact: ____________________

Office Fax#: ____________________ Office Phone #: ____________________

Drug Requested AND Diagnosis

☐ **Hepatitis B Vaccine**

- ☐ High or Intermediate Risk, diagnosis code: ____________________
- ☐ Other (please provide diagnosis and code): ____________________

☐ **Intravenous Immune Globulin (IVIG)**

- ☐ Primary Immunodeficiency, diagnosis code: ____________________
- ☐ Other, diagnosis and code: ____________________

☐ **Nebulized solutions**. Please circle drug: acetylcysteine (Mucomyst®), albuterol (Accuneb®, Proventil®), cromolyn (Intal®), DuoNeb®, ipratropium, metaproterenol (Alupent®), Pulmicort® Respules, Pulmozyme®, TOBI®, Xopenex®

- ☐ For use in a nebulizer
- ☐ Other (please describe and provide diagnosis code): ____________________

☐ **Immunosuppressants.** Please circle drug: Cellcept®, Imuran®, cyclosporine (Neoral®, Sandimmune®. Gengraf®), Rapamune®, and Prograf®

- ☐ Transplant, date of transplant: ____________________
  Transplant paid by Medicare? ☐ Yes ☐ No
- ☐ Other (please provide diagnosis code):______________

☐ **Erythropoietin.** Please circle drug: Aranesp ®, Epogen®, Procrit®

- ☐ Anemia with Chronic Renal Failure, diagnosis code: ______________
  Is member currently on Dialysis? ☐ Yes ☐ No
- ☐ Other (please provide diagnosis and code): ____________________

(pending approval) deliver to: ☐Physician's office ☐Member's home ☐Office supply (**NO AUTH. REQUIRED)**

Please add any other supporting medical information that may be useful in the decision-making process:

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FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only

Document #____________________ Coverage effective date / /

LOB______________ Processor Initials__________

M F Rx coverage Y N STANDARD - SELECT Date______________

Previous Auth Y N

Approved ☐ **B** ☐**D** **Reviewer Initials**__________ Date____________

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