# PRIOR AUTHORIZATION REQUEST FORM
## MEDICARE PART D
### Oral Chemotherapy & Immunosuppressants

DATE OF REQUEST:_____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

☑ PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

_____

PHONE #_____FAX #_____

CONTACT NAME _____

PROVIDER SIGNATURE _____

**Drug Requested:** _____

**Check one:** □ Initial Request □ Extension Request □ Other:_____
□ Intravenous □ Oral

**Dose/frequency/quantity**: _____

**Diagnosis**_____ **ICD-9 code** _____

**For Oral Immunosuppressants** (e.g. azathioprine, cyclosporine, sirolimus, tacrolimus, methylprednisolone, prednisone, prednisolone) compete the following:
Transplant Type:_____ Transplant Date:_____

| | | | |
|---|---|---|---|
| Was the transplant Medicare approved? | ❑ YES | ❑ NO | |
| Was the transplant prior to member's Medicare benefit eligibility? | ❑ YES | ❑ NO | |
| Is the immunosuppressant being prescribed for a diagnosis other than the transplant? | ❑ YES | ❑ NO | |
| Is the member receiving corticosteroids? | ❑ YES | ❑ NO | |
| Will IV med be administered in the home?<br>If yes, provide documentation to support medical necessity vs. oral agent(s) | ❑ YES | ❑ NO | ❑ NA |

*Immunosuppressants used for Medicare approved transplants are covered under the Part B benefit. (36 months post- kidney transplant if member < 65 YO). All non-Medicare transplants and other diagnoses are a Part D benefit. Prescriptions for immunosuppressive drugs under the Part B benefit should be non-refillable and limited to a 30-day supply. Medicare Part D members will not require a prior authorization for corticosteroids. Medicare members without a prescription benefit will require a Part B vs Part D determination for corticosteroids.*

**For Oral Chemotherapy Agents** (e.g. cyclophosphamide, melphalan) complete the following:

| | | |
|---|---|---|
| Is drug requested being used for a cancer diagnosis?<br>If yes, provide diagnosis: _____ | ❑ YES | ❑ NO |
| Is the oral chemotherapy being for a diagnosis other than the treatment of cancer?<br>If yes, provide diagnosis: _____ | ❑ YES | ❑ NO |

*Drugs taken orally for cancer will be covered under the "B" benefit if they have the same active ingredients (or pro-drug) as injectable forms that would have been administered by a physician.*

*Refer to Medicare Part B vs Part D policy for additional prior authorization criteria & documentation requirements*

***FAX THIS REQUEST TO:***
Medicare Part D **1-800-401-0915**
*(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)*