



PRIOR AUTHORIZATION REQUEST FORM  
MEDICARE PART D  
**Nebulizer Solutions**

DATE OF REQUEST: _____	<u>PROVIDER INFORMATION</u>
<u>MEMBER INFORMATION</u>	NAME _____
NAME _____	NPI # _____
ID # _____	ADDRESS _____
BIRTHDATE _____	_____
<input checked="" type="checkbox"/> <b>PLEASE NOTE:</b> By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.	PHONE # _____ FAX # _____
	CONTACT NAME _____
	PROVIDER SIGNATURE _____

**Drug Requested:** \_\_\_\_\_

**Check one:**       Initial Request       Extension Request       Other: \_\_\_\_\_

**Dose/frequency/quantity:** \_\_\_\_\_

**Indicate where the drug will be administered:** (check one)

Home/Self       SNF/LTC facility\*       Home Care Service (Vendor Name: \_\_\_\_\_)

**Diagnosis:** (check one)  COPD (ICD-9: 491-492.8)

Cystic Fibrosis (ICD-9: 277.02)

Brochiectasis (ICD-9: 494.0, 494.1, 748.61, 011.50-011.56)

Pulmonary secretions (ICD-9: 480.0 – 508.9, 786.4)

Other (Diagnosis \_\_\_\_\_ ICD-9: \_\_\_\_\_)

HIV (ICD-9: 042) AND Pneumocystosis (ICD-9: 136.3) AND Organ transplant complication (ICD-9: 996.8 – 996.89)

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