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.

PRESCRIBING PHYSICIAN 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-10 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? 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? If yes, provide diagnosis: ____	☐ YES	☐ NO
Is the oral chemotherapy being for a diagnosis other than the treatment of cancer? 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, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)