PRIOR AUTHORIZATION REQUEST FORM
MEDICARE PART D
Nebulizer Solutions

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 ______________________________________

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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-10: J44)

☐ Cystic Fibrosis (ICD-10: E84)

☐ Brochiectasis (ICD-10: J47.9)

☐ Pulmonary secretions

☐ Other (Diagnosis_________________________ICD-10: ______________)

☐ HIV AND Pneumocystosis (ICD-10: B59) AND Organ transplant complication (ICD-10: T86.90)

FAX THIS REQUEST TO:

Medicare Part D **1-800-401-0915**

(Preferred Gold, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)