



**Independence  
Blue Cross**

**Prior Authorization Form**

**ESRD Prior authorization for Part B/D coverage**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested: \_\_\_\_\_  
(one drug per form only)

Date: \_\_\_\_\_

Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_

Office Phone: \_\_\_\_\_

**1. DIAGNOSIS FOR DRUG REQUESTED:** \_\_\_\_\_

**2. Is member currently on Dialysis?**  YES  NO

**Dialysis Start Date:** \_\_\_\_\_ (mm/dd/yy)

**Dialysis End Date:** \_\_\_\_\_ (mm/dd/yy)

**3. Is the drug prescribed to be used for an ESRD related condition?**  YES  NO

**REASON FOR ADMINISTRATION OF DRUG (must check one):**

- Access Management : drug being used to ensure access by removing clots from grafts, reverse anticoagulation if too much medication is given, and provide anesthetic for access placement**
- Anemia Management: drug used to stimulate red blood cell production and/or treat or prevent anemia**
- Anti-Infectives: (Vancomycin IV and Cubicin IV (Daptomycin) Only)**
- Bone and Mineral Metabolism: drug used to prevent bone disease secondary to Dialysis**
- Cellular Management: drug used for deficiencies of naturally occurring substances**

**4. Does Prescriber receive a monthly capitation payment to manage ESRD beneficiaries care?**  
 YES  NO

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

**FAX: (888) 671-5285 or EMAIL: [FSS\\_Standard\\_Medicare@catalystrx.com](mailto:FSS_Standard_Medicare@catalystrx.com)  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**