



**Independence
Blue Cross**

Prior Authorization Form

Medicare Administrative Prior authorization for Part B/D coverage

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Office Contact: _____
 Office Fax #: _____ Office Phone: _____

HEPATITIS B VACCINE
 High or Intermediate Risk, diagnosis code: _____
 Other (please provide diagnosis and code): _____

PARENTERAL NUTRITION (TPN) (Drug requested) _____
 Does the patient have a permanent dysfunction of the digestive tract? Yes No

ALL OTHER INTRAVENOUS (IV) (Drug requested) _____
 Is the requested drug administered in the *home setting via an external infusion pump*? Yes No

ORAL CHEMOTHERAPY AGENTS (Drug requested) _____
 Diagnosis and code _____

INTRAVENOUS IMMUNE GLOBULIN (IVIG)
 Primary Immunodeficiency, diagnosis code: _____
 Other, diagnosis and code: _____

NEBULIZED SOLUTIONS (Please circle drug): acetylcysteine (Mucomyst®), albuterol (Accuneb®, Proventil®), cromolyn (Intal®), DuoNeb®, ipratropium, metaproterenol (Alupent®), Pulmicort® Respules, Pulmozyme®, TOBI®, Xopenex®
 For use in a nebulizer
 Other, diagnosis and code: _____

IMMUNOSUPPRESSANTS (Please circle drug): Cellcept®, Imuran®, cyclosporine (Neoral®, Sandimmune®, Gengraf®), Rapamune®, and Prograf®
 Transplanted organ (specify) _____
 Transplant, date of transplant: _____
 Transplant paid by Medicare? Yes No
 Other, diagnosis and code: _____

ERYTHROPOIETIN (Please circle drug): Aranesp®, Epogen®, Procrit®
 Anemia with Chronic Renal Failure, diagnosis code: _____
 Is member currently of Dialysis? Yes No
 Other, diagnosis and code: _____

Pending approval deliver to: Physician's office Member's home Office supply (NO AUTH REQUIRED)

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
 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**