Prior Authorization Form

Medicare Administrative Prior Authorization for Part B/D Coverage

Please provide ALL requested information. Incomplete forms will not 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: _____
- ☐ Low Risk : _____

☐ **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 _____

☐ **NEBULIZED SOLUTIONS (***Examples*): acetylcysteine (Mucomyst®), albuterol (Accuneb®, Proventil®), cromolyn (Intal®), DuoNeb®, ipratropium, metaproterenol (Alupent®), Pulmicort® Respules, Pulmozyme®, TOBI®, Xopenex®, Formoterol (Perforomist), Iloprost (Ventavis®), Pentamidine isethionate (Nebupent ®), Ribavirin (Virazole®), sodium chloride for inhalation (Hyper-Sal, Nebusal), Treprostinil (Tyvaso)

- ☐ For use in a nebulizer
- ☐ Other route of administration (*Please specify)*_____
- ☐ Diagnosis and code: _____

☐ **IMMUNOSUPPRESSANTS** *(Examples)***:** Cellcept®, Imuran®, cyclosporine (Neoral®, Sandimmune®, Gengraf®), Rapamune®, and Prograf®

- ☐ **Transplanted organ (specify)**_____
- ☐ **Date member entitled to or qualified for Medicare Part A** _____
- ☐ Other, diagnosis _____

☐ **ESRD DRUGS (***Examples)***:** Aranesp®, Epogen®, Procrit®,Activase, Boniva, Calcitriol, Calcium gluconate, Carnitor, Cetacaine medical kit, Cubicin, Desferal, Hectorol, Heparin 1,000units/ml vial, Levocarnitine, Lido/Prilocaine (Emla), Miacalcin, Pamidronate, Pre-attached LTA kit (lidocaine soln 4%), Protamine, Refludan 50mg vial, Retavase, Rocaltrol, Synera Dis, Vancomycin, Vibativ, Zemplar

Is medication to be used for an ESRD related condition? ☐ **Yes** ☐ **No**

Please note that if the medication use is ESRD related, the member should obtain it at a dialysis center.

☐ Other, diagnosis and code: _____

Pending approval deliver to: ☐ **Physician's office** ☐ **Member's home**

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