# MEDICARE PART D
## B VERSUS D COVERAGE DETERMINATION
PRESCRIBER FAX FORM

Blue Cross Blue Shield of Rhode Island

**ONLY the prescriber may complete this form. This form is for Medicare Part D prospective, concurrent, and retrospective reviews.**

| | |
|---|---|
| **Please fax or mail this form to:**<br>**TOLL FREE**<br>**Fax: 800-693-6703 Phone: 800-693-6651** | **Prime Therapeutics LLC**<br>**Attn: Medicare Appeals Department**<br>**1305 Corporate Center Drive**<br>**Eagan, MN 55121** |

**The following documentation is REQUIRED.** For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary. To submit this form electronically, please click here or go to covermymeds.com.

**Per CMS requirements – all standard requests are completed within 72 hours (including weekends)**

If you request an expedited review, you certify that applying the 72 hour standard review time frame could seriously harm the patient's life, health or ability to regain maximum function. Please check the box to request an expedited review: ☐

**PATIENT, INSURANCE and PRESCRIBER/CLINIC INFORMATION** **Today's Date:** _____

| | | | |
|---|---|---|---|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yy): |
| Insurance ID Number: | Patient Telephone Number: | | |
| Prescriber Name: | Prescriber NPI#: | Specialty: | Clinic Contact Person's Name: |
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Clinic Phone #: | Clinic Secure Fax #: | |
| Is the patient a long term care facility resident? ☐ Yes ☐ No If yes, please provide the LTC facility contact's name, telephone and fax numbers | | | |
| LTC Contact Name: | LTC Phone #: | LTC Secure Fax #: | |
| Patient's Diagnosis (ICD code, plus description): | | | |
| Medication Requested: | Strength: | | |
| Dosing Schedule: | Quantity per Month: | | |

**All Requests:**

1. Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No
   **If yes,** when was treatment with the requested medication started? _____
2. Is the patient currently receiving dialysis? ..... ☐ Yes ☐ No
   **If yes,** is the prescriber a nephrologist, nurse practitioner, or physician who receives a monthly capitation payment to manage ESRD patients' care? ..... ☐ Yes ☐ No
3. Is the diagnosis of the requested medication covered by Medicare Part A or B? ..... ☐ Yes ☐ No
4. Has the member exhausted their Medicare Part A benefits? ..... ☐ Yes ☐ No
5. Please list all reasons for selecting the **requested medication, dosing schedule, and quantity** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
6. Please list all the medications the patient has **tried and failed** for treatment of this diagnosis: **None:** ☐
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
7. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. _____

**Please continue on page 2.**

| Patient Name (First): | Last: | M: | DOB (mm/dd/yy): |
|---|---|---|---|
| | | | |

For **antiemetic (nausea/vomiting)** medication requests**:**

8. Is the patient diagnosed with nausea/vomiting? ☐ Yes ☐ No
   **If yes,** what is the cause? _____
9. Is the requested medication being used with chemotherapy? ☐ Yes ☐ No
   **If yes,** will this drug be used as full replacement for IV antiemetic drugs within 2 hours of cancer treatment and continued for a period not to exceed 48 hours after chemotherapy? ☐ Yes ☐ No
10. If the requested medication is being used with chemotherapy, is the requested medication being given alone (with no other antiemetics)? ☐ Yes ☐ No
    **If no,** please list other antiemetics to be used with the requested medication and include the route of administration (IV, oral, etc.): _____

For **immunosuppressive or steroid** medication requests:

11. Is it being used for a transplant? ☐ Yes ☐ No
    **If yes,** what was the date of the transplant procedure? _____

For **Hepatitis B vaccines** request:

12. Is the patient at high/medium risk of contracting Hepatitis B? ☐ Yes ☐ No

For **chemotherapy or oncology** medication requests:

13. Is the requested medication being prescribed for the treatment of cancer? ☐ Yes ☐ No

For **total parenteral nutrition** medication requests:

14. Does the patient have a permanent, non-functioning gastrointestinal (GI) tract? ☐ Yes ☐ No

For **insulin or injectable** medication requests:

15. Is the requested medication being used via a pump? ☐ Yes ☐ No

For **inhaled** medication requests:

16. Is the requested medication being used with a nebulizer? ☐ Yes ☐ No

For **Rabies or Tetanus Toxoid** vaccine requests:

17. Is the vaccine being requested due to the treatment of an injury or direct exposure? ☐ Yes ☐ No

For **Immune Globulin or IVIG** medication requests:

18. Is the requested medication being administered via a pump? ☐ Yes ☐ No
19. Is the requested medication being administered subcutaneously? ☐ Yes ☐ No
20. Is the requested medication being administered intravenously? ☐ Yes ☐ No
21. Where does the patient currently live?
    ☐ Home ☐ Long Term Care (LTC) Facility ☐ Other: _____