MEDICARE PART D B VERSUS D COVERAGE DETERMINATION

PRESCRIBER FAX FORM



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:

TOLL FREE

Fax: 800-693-6703 Phone: 800-693-6651 Eagan, MN 55121

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

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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):

ent Name (First): Last:							M: DOB (mm/dd/yy):			
ance ID Number:	r: Patient Telephone Number:									
Prescriber Name: Prescriber NPI#:					Specialty:			Clinic Contact Person's Name:		
Name:				(Clir	nic Address:				
City, State, Zip:					Clinic Phone #:			Clinic Secure Fax #:		
patient a long term care facility res	sident?	☐ Yes	☐ No If y	es, please	e pı	rovide the LTC facility	/ conta	ct's name, telephone and fax numbers		
Contact Name:			LTC Phor	ne #:	e#: LTC S			Secure Fax #:		
ent's Diagnosis (ICD code, plus	descrip	otion):								
Medication Requested: Strength:										
ng Schedule:		Quantity per Month:								
equests:										
•	vith the	requeste	ed medicat	tion?				∏ 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			
Please list all reasons for select	ting the	request	ed medic	ation, do	osi	ng schedule, and	quan	tity over alternatives (e.g.		
contraindications, allergies or hi	istory of	f adverse	e drug read	ctions to a	alte	ernatives, lower do	se trie	ed)		
Please list any other medication	ns the pa	atient wil	ll use in c o							
	riber Name: Name: State, Zip: patient a long term care facility rescontact Name: nt's Diagnosis (ICD code, plus cation Requested: ng Schedule: equests: s the patient currently treated v If yes, when was treatment s the patient currently receiving If yes, is the prescriber a ner payment to manage ESRD payment to ma	riber Name: Name: State, Zip: Patient a long term care facility resident? Contact Name: Int's Diagnosis (ICD code, plus descript cation Requested: Ing Schedule: Requests: Is the patient currently treated with the lif yes, when was treatment with the steep the patient currently receiving dialys lif yes, is the prescriber a nephrology payment to manage ESRD patients as the diagnosis of the requested medical has the member exhausted their Medical Please list all reasons for selecting the contraindications, allergies or history of the patients of the patients of the requested medical please list all the medications the patients of the patients o	Prescriber NPI# Name: State, Zip: Patient a long term care facility resident? Yes Contact Name: Int's Diagnosis (ICD code, plus description): Cation Requested: Ing Schedule: Pequests: If yes, when was treatment with the requeste If yes, when was treatment with the requeste If yes, is the prescriber a nephrologist, nurse payment to manage ESRD patients' care? Is the diagnosis of the requested medication con Has the member exhausted their Medicare Pare Please list all reasons for selecting the request contraindications, allergies or history of adverse Please list all the medications the patient has tre Date(s): Date(s): Date(s): Date(s):	Prescriber NPI#: Name:	Prescriber NPI#: Name:	Name: Clinic Phone Prescriber NPI#: Clinic Phone Prescriber Prescriber	Prescriber NPI#: Specialty: Name: Clinic Address: State, Zip: Clinic Phone #: patient a long term care facility resident?	riber Name: Prescriber NPI#: Specialty:		

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):				
For antiemetic (nausea/vomiting) medica	tion requests:	1					
8. Is the patient diagnosed with nausea/vomiting?							
If yes, what is the cause?							
9. Is the requested medication being use	d with chemotherapy?			Yes 🗌 No			
If yes, will this drug be used as full	replacement for IV antiemetic drugs within 2 hou	urs of	cancer				
treatment and continued for a perio	d not to exceed 48 hours after chemotherapy?			Yes 🗌 No			
10. If the requested medication is being us	sed with chemotherapy, is the requested medica	tion b	eing given alone				
(with no other antiemetics)?				Yes 🗌 No			
If no, please list other antiemetics to	be used with the requested medication and inc	lude t	ne route of				
administration (IV, oral, etc.):							
For immunosuppressive or steroid medi	cation requests:						
				Yes □ No			
•	nsplant procedure?						
,							
For Hepatitis B vaccines request:							
12. Is the patient at high/medium risk of co	ontracting Hepatitis B?			Yes 🗌 No			
For chemotherapy or oncology medication	on requests:						
	scribed for the treatment of cancer?			Yes 🗌 No			
For total parenteral nutrition medication							
14. Does the patient have a permanent, no	on-functioning gastrointestinal (GI) tract?			Yes ☐ No			
For insulin or injectable medication reque	ests:						
15. Is the requested medication being use	d via a pump?			Yes □ No			
For inhaled medication requests:							
	d with a nebulizer?			Ves □ No			
10. Is the requested medication being use	u wur a riebuilzer:			163 🗀 110			
For Rabies or Tetanus Toxoid vaccine re-	quests:						
17. Is the vaccine being requested due to	the treatment of an injury or direct exposure?			Yes □ No			
For Immune Globulin or IVIG medication	raquasts						
	ninistered via a pump?		Π,	Yes □ No			
19. Is the requested medication being administered subcutaneously?20. Is the requested medication being administered intravenously?							
21. Where does the patient currently live?				. 55 🗀 140			
☐ Home ☐ Long Term Care (Li	TC) Facility						
<u> </u>	tion is intended only for the use of the individual entity			aine			
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