CarePartners of Connecticut

Coverage Determination and Prior Authorization Request Form: Medicare "Part B versus Part D" Drugs

This form is for providers to submit information to CarePartners of Connecticut to help determine drug coverage and proper payment under Medicare "Part B versus Part D" per the Centers for Medicare and Medicaid Services (CMS). You may also submit a request for coverage using the Request For Medicare Prescription Drug Coverage Determination form.

- If you check "**YES**" to the question about the drug, the drug may be paid for by Medicare **Part B**
- If you check "**NO**" to the question about the drug, the drug may be paid for by Medicare **Part D**

Does the member's condition require Expedited Review [24 Hours]? ☐ Yes* ☐ No

**By checking this box, I certify that the 72-hour standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.*

Fax or mail this completed form to: 617.673.0956 or 705 Mount Auburn Street, Watertown, MA 02472

PATIENT INFORMATION	**PRESCRIBER INFORMATION**
Name:_____ Date:_____ DOB:_____ Member ID: _____ Drug Requested:_____ Strength:_____ Dose:_____ Dosage Form: _____	Name:_____ Specialty:_____ Provider ID:_____ Phone: _____ Fax:_____ Office Contact: _____ **Prescriber Signature (required)**:_____ By signing this form, I attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by CarePartners of Connecticut.

Hepatitis B Vaccine: Engerix B, Recombivax HB		
Is this member at intermediate to high risk of contracting Hepatitis B? High/Intermediate risk defined as: ESRD patients, hemophiliacs receiving Factor VIII or IX, clients or staff of an institution for the developmentally disabled, HIV positive patients, persons who live in the same household as a Hepatitis B Virus (HBV) carrier, men who have sex with other men, illicit injectable drug abusers, health care professionals with frequent contact with blood or blood-derived bodily fluids during routine work)	☐ **Yes**	☐ **No**
Immunosuppressants: Astagraf XL, Atgam, Azasan, azathioprine, Cellcept, cyclosporine, Envarsus XR, gengraf, mycophenolate, Nuolojix, Rapamune, Simulect, sirolimus, tacrolimus, Thymoglobulin, Zortress		
Did this member have a Medicare-covered transplant and/or had Medicare at time of transplant? Type of transplant: _____ Date of transplant: _____	☐ **Yes**	☐ **No**
Is the drug being used to prevent transplant rejection?	☐ **Yes**	☐ **No**

Is the drug being used to treat a condition related to the transplant?	☐ **Yes**	☐ **No**
Inhalant Solutions: acetylcysteine, albuterol nebulizer solution, albuterol/ipratropium, Bethkis, Brovana, budesonide solution, cromolyn sodium, ipratropium bromide, levalbuterol, Nebupent, Perforomist, Pulmozyme, tobramycin for inhalation		
Is this drug being delivered via DME (via nebulizer in the home – Note: LTC is not considered "home")? Please indicate diagnosis and route of administration if not being nebulized: _____	☐ **Yes**	☐ **No**
Oral Antiemetics: Akynzeo, Aloxi, Anzemet, aprepitant, Cesamet, dronabinol, Emend, granisetron, ondansetron, Varubi		
Is this drug being used to treat chemotherapy-induced nausea and vomiting as a full replacement for IV administration within 48 hours of cancer treatment?	☐ **Yes**	☐ **No**
Oral Chemotherapy: cyclophosphamide, methotrexate, Trexall		
Is this drug being used to treat cancer?	☐ **Yes**	☐ **No**
Parenteral Nutrition–Amino Acid & Lipids: amino acid solutions, amino acid with electrolyte and/or calcium solutions, IV lipid emulsion		
Does this member have a "permanently" non-functioning digestive tract? (This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration (at least 3 months), the test of permanence is considered met.)	☐ **Yes**	☐ **No**