35045

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Medicare Part D Prior Authorization Request Form (page 1 of 2)

Please complete both pages and return to Medco by fax at **1-800-837-0959.**
Please indicate if you are requesting urgent processing ☐ Yes
If yes, state rationale for urgent processing: ______________________________
If you have any questions, you may contact us toll-free at **1-800-753-2851.**

PATIENT INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Date of Birth: |__|__|/|__|__|/|__|__|__|__| Telephone: |__|__|__|-|__|__|__|-|__|__|__|__|

Medco Member ID Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|

MEDICATION (that requires a coverage review)

Drug Name and Strength: ______________________________ Qty: ____________

Directions (SIG.):______________________________

Diagnosis: ______________________________

PRESCRIBER INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|

SECURE Fax: |__|__|__| - |__|__|__| - |__|__|__|__| Telephone: |__|__|__| - |__|__|__| - |__|__|__|__|

SECTION A: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

1.	☐ Yes	☐ No	Has your patient experienced INTOLERANCE or is INTOLERANCE SUSPECTED with any of the preferred alternatives?
2.	☐ Yes	☐ No	Has your patient experienced THERAPEUTIC FAILURE with any of the preferred alternatives or would failure be suspected with any of the preferred alternatives?
3.	☐ Yes	☐ No	Is this patient UNABLE TO USE the preferred alternative(s) because of DOSAGE FORM?
4.	☐ Yes	☐ No	Are there any preferred alternative(s) that can be used to treat this patient or patient's condition?
5.	☐ Yes	☐ No	Is a greater drug quantity necessary to achieve the prescribed dose?
6.	☐ Yes	☐ No	Is a greater quantity of medication needed to accommodate the frequency of use?

Location: Nevada Call Center (15) Case Id: 9999999

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Medicare Part D Prior Authorization Request Form (page 2 of 2)

PLEASE RE-ENTER THE FOLLOWING INFORMATION ONTO THIS PAGE
PATIENT INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Medco Member ID Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

MEDICATION (that requires a coverage review)

Drug Name and Strength: ____

Diagnosis: ____

SECTION B: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

1.	☐ Yes	☐ No	Is the prescriber a Medicare-participating prescriber?	
2.	☐ Yes	☐ No	☐ Unknown	Is this patient currently enrolled in Part B coverage?
3.	☐ Yes	☐ No	☐ Unknown/ pending	Has coverage been denied under the Part B benefit?
4.	☐ Yes	☐ No	If YES to question 3, has Part B coverage of this medication been denied because of determination of lack of medical necessity?	
5.	☐ Yes	☐ No	If YES to question 3, has Part B coverage of this medication been denied because of member ineligibility?	

SECTION C: COMPLETE IF APPLICABLE: PATIENTS USING IMMUNOSUPPRESSANT MEDICATIONS

1.	☐ Yes	☐ No	Is the immunosuppressant medication being used subsequent to a transplant?
	If you answered YES to question 1, please proceed to questions 2 and 3.		
2.	☐ Yes	☐ No	Did the transplant occur at a Medicare-approved facility?
	In accordance with CMS Immunosuppressive Drugs Policy Article (A25366), effective July 2008 Medicare Part B will cover immunosuppressant agents when used for a transplant if the beneficiary was enrolled in Part A at the time of the transplant and the transplant occurred at a Medicare-approved facility, whether or not Medicare Part A made payments for the transplant.		
3.	☐ Yes	☐ No	Was the patient enrolled in Medicare Part A at the time of the transplant?

SECTION D: COMPLETE IF APPLICABLE: PATIENTS USING CHEMOTHERAPY AGENTS

1.	☐ Yes	☐ No	Is the patient currently receiving or has the patient previously received the prescribed chemotherapy agent?

SECTION E: IF APPLICABLE, PLEASE PROVIDE ADDITIONAL RATIONALE BELOW

____

____

Prescriber's Signature: ____

FAX COMPLETED FORM TO 1-800-837-0959. (Please do **not** send with a cover sheet.)

Location: Nevada Call Center (15) Case Id: 9999999

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