



**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 1 Wellness Way, Canton, MA 02021-1166**

<b>PATIENT INFORMATION</b> Name: _____ Date: _____ DOB: _____ Member ID: _____ Drug Requested: _____ Strength: _____ Dose: _____ Dosage Form: _____		<b>PRESCRIBER INFORMATION</b> Name: _____ Specialty: _____ Provider ID: _____ Phone: _____ Fax: _____ Office Contact: _____ <b>Prescriber Signature (required):</b> _____ <small>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.</small>	
<b>Hepatitis B Vaccine:</b> Enderix B, Recombivax HB			
<b>Is this member at intermediate to high risk of contracting Hepatitis B?</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)		<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Immunosuppressants:</b> Astagraf XL, Atgam, Azasan, azathioprine, Cellcept, cyclosporine, Envarsus XR, gengraf, mycophenolate, Nuolojix, Rapamune, Simulect, sirolimus, tacrolimus, Thymoglobulin, Zortress			
<b>Did this member have a Medicare-covered transplant and/or had Medicare at time of transplant?</b> Type of transplant: _____ Date of transplant: _____		<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Is the drug being used to prevent transplant rejection?</b>		<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>

<b>Is the drug being used to treat a condition related to the transplant?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Inhalant Solutions:</b> acetylcysteine, albuterol nebulizer solution, albuterol/ipratropium, Bethkis, Brovana, budesonide solution, cromolyn sodium, ipratropium bromide, levalbuterol, Nebupent, Perforomist, Pulmozyme, tobramycin for inhalation		
<b>Is this drug being delivered via DME (via nebulizer in the home – Note: LTC is not considered “home”)?</b> Please indicate diagnosis and route of administration if not being nebulized: _____	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Oral Antiemetics:</b> Akynzeo, Aloxi, Anzemet, aprepitant, Cesamet, dronabinol, Emend, granisetron, ondansetron, Varubi		
<b>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?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Oral Chemotherapy:</b> cyclophosphamide, methotrexate, Trexall		
<b>Is this drug being used to treat cancer?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Parenteral Nutrition–Amino Acid &amp; Lipids:</b> amino acid solutions, amino acid with electrolyte and/or calcium solutions, IV lipid emulsion		
<b>Does this member have a “permanently” non-functioning digestive tract?</b> (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.)	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>