Coverage Determination Request Form - Anti-Rejection Drugs, Immunosuppressants (Medicare Part B vs. Part D)

This request is: ☐ **Expedited* (Urgent)** ☐ **Standard** (**Non-Urgent)**

*Expedited means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Please note: All information below is required to process this request. Any information that is incomplete or illegible will delay the review process.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Medication Information (required)		
Indicate Medication Requested: (NOTE: Drugs below are a representative list, only. See plan formulary to verify coverage status.) ☐ azathioprine (IMURAN / AZASAN) ☐ belatacept (NULOJIX) ☐ cyclophosphamide (CYTOXAN) ☐ cyclosporine (SANDIMMUNE) ☐ cyclosporine modified (GENGRAF / NEORAL) ☐ everolimus (ZORTRESS) ☐ lymphocyte immune globulin, antithymocyte globulin (equine) (ATGAM) ☐ lymphocyte immune globulin, antithymocyte globulin (rabbit) (THYMOGLOBULIN) ☐ methotrexate (TREXALL) ☐ methylprednisolone sodium (A-METHAPRED, SOLU-MEDROL) ☐ mycophenolate mofetil (CELLCEPT) ☐ mycophenolate sodium (MYFORTIC) ☐ sirolimus (RAPAMUNE) ☐ tacrolimus (ASTAGRAF XL / ENVARSUS XR / HECORIA / PROGRAF) ☐ other: _____	Strength:	Dosage Form:
Quantity Prescribed:	Directions for Use:	

B vs. D Primary Billing Determination (required)

1) Is the requested medication prescribed for the treatment and/or prevention of transplant rejection?

☐ YES (*Continue to Question 2*)

☐ NO (*Continue to Question 6*)

2) Is the request for intravenous (IV) administration of azathioprine or methylprednisolone?

☐ YES (*Continue to Question 3*)

☐ NO (*Continue to Question 4*)

3) Is the patient unable to tolerate or absorb the oral equivalent?

☐ YES (***Complete Section A or B below***)

☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

4) Is the request for intravenous (IV) administration of antithymocyte globulin (ATGAM / THYMOGLOBULIN), cyclosporine (SANDIMMUNE INJ), or tacrolimus (PROGRAF INJ)?

☐ YES (*Continue to Question 5*)

☐ NO (***Complete Section A or B below***)

5) Is the requested medication being administered in the home setting?

☐ YES ***(Complete Part D Coverage Determination Criteria section below)***

☐ NO (***Complete Section A or B below***)

6) Is the request for oral cyclophosphamide or methotrexate?

☐ YES (*Continue to Question 7*)

☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

7) Is the requested medication prescribed for the treatment of cancer?

☐ YES ***(Bill to Medicare Part B)***

☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

Section A: Treatment and/or Prevention of Kidney Transplant Rejection

1. Did the transplant meet Medicare coverage criteria in effect at the time (e.g., approved facility for kidney transplant; national and/or local medical necessity criteria; etc.)?

☐ Yes (*Continue to Question 2*)

☐ No ***(Complete Part D Coverage Determination Criteria section below)***

2. Was the patient enrolled in Medicare Part A at the time of the transplant?

☐ Yes (*Continue to Question 3*)

☐ No ***(Complete Part D Coverage Determination Criteria section below)***

3. Is the member's current Medicare coverage due to age or disability?

☐ Yes ***(Bill to Medicare Part B)***

☐ No (*Continue to Question 4*)

4. Was the patient's Medicare entitlement, at the time of the transplant, due to ESRD ONLY?

☐ Yes (*Continue to Question 5*)

☐ No ***(Bill to Medicare Part B)***

5. Was the member's Kidney Transplant performed more than 36 months ago?

☐ Yes ***(Complete Part D Coverage Determination Criteria section below[1])***

☐ No ***(Bill to Medicare Part B[1])***

[1]If commercial coverage exists, it is the sole payer for the first 3 months following a kidney transplant. After 3 months, Medicare Part B is the secondary payer for the next 30 months, then becomes the primary payer until coverage ends 36 months after the transplant; unless/until the patient becomes entitled to Medicare due to age or disability, then Medicare Part B pays primary again.

Section B: Treatment and/or Prevention of Other Organ Transplant Rejection (including heart, liver, marrow/stem cell, and lung, as well as pancreatic and intestinal for select circumstances):

Please indicate transplant type: _____

1. **Did the transplant meet Medicare coverage criteria in effect at the time (e.g., approved facility for heart, intestinal, liver, lung, or heart/lung transplant; national and/or local medical necessity criteria; etc.)?**
   - ☐ Yes (*Continue to Question 2*)
   - ☐ No ***(Complete Part D Coverage Determination Criteria section below)***
2. **Was the patient enrolled in Medicare Part A at the time of the transplant?**
   - ☐ Yes ***(Bill to Medicare Part B)***
   - ☐ No ***(Complete Part D Coverage Determination Criteria section below)***

Part D Coverage Determination Criteria (required)

The following requirements need to be met before this drug can be covered by the Part D plan. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Which condition is the drug being used for?

☐ Prescribed for prophylaxis of organ rejection concomitantly with basiliximab induction, mycophenolate mofetil, and corticosteroids in adult Epstein-Barr virus seropositive kidney transplant recipients. **(belatacept (NULOJIX) ONLY)**

☐ Other diagnosis (if transplant, indicate organ): _____ ICD-10 Code (s): _____

Please Note: This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration (FDA) – that is, that the FDA has approved the drug for the diagnosis or condition for which it is being prescribed.
- Supported by any of the following reference books – American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and/or the USPDI or its successor.

This drug requires the following prior authorization criteria be met in order to be covered under the Part D plan:

☐ If prescribed for **belatacept (NULOJIX):**

☐ Prescribed for the prevention of kidney transplant organ rejection.

AND ☐ Patient is immune to the Epstein-Barr virus (EBV seropositive).

AND ☐ Patient will be prescribed concurrent therapy with mycophenolate and corticosteroids.

AND ☐ Patient is 18 years of age or older.

AND ☐ Prescriber is experienced in immunosuppressive therapy and management of transplant patients.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other pertinent information the physician feels is important to this review? ☐ Yes ☐ No (If yes, please explain, below)

_____

_____

_____

Exception Requests (optional)

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would this medication likely be the most effective option for this patient? ☐ Yes ☐ No
(If yes, please explain why, below)

_____

_____

_____

If the patient is currently using this medication, would changing the current regimen likely result in adverse effects for the patient? ☐ Yes ☐ No (If yes, please explain why, below)

_____

_____

_____

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

Please Note:

- This request may be denied or dismissed unless all required information is received.
- Your office will receive a response via fax.
- For urgent requests, please call (866) 270-3877.
- For real time submission 24/7 please visit the secure prescriber portal on our plan's website for the appropriate form and instructions on how to submit your request.

Authorization Period: 1 Year - subject to formulary change and member eligibility.

PLEASE FAX COMPLETED FORM TO: 855-668-8552