Coverage Determination Request Form - ESRD/Dialysis-Related Drugs (Medicare B vs. 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.) ☐ Indicate Drug: _____	Strength:	Dosage Form:
Quantity Prescribed:	Directions for Use:	

B vs. D Primary Billing Determination (required)

Requests submitted with CKD diagnosis are subject to BvD Primary Billing Determination for the coverage categories listed below (select one and answer the question below):

☐ Access Management: Drugs used to ensure access by removing clots from grafts, reverse anticoagulation if too much medication is given, and provide anesthetic for access placement. This category includes drugs such as ARGATROBAN, heparin sodium (porcine), heparin (porcine) in sodium chloride and heparin sod (porcine) in D5W.

☐ Bone and mineral metabolism: Drugs used to prevent/treat bone disease secondary to dialysis. This category includes drugs such as calcitriol, calcitonin (salmon), doxercalciferol, ibandronate sodium, pamidronate disodium, paricalcitol, SENSIPAR, and zoledronic acid (ZOMETA).

☐ Cellular management: Drugs used for deficiencies of naturally occurring substances needed for cellular management. This category includes levocarnitine.

☐ Anemia management: Drugs used to treat anemia in a patient diagnosed with ESRD who currently requires dialysis. This category includes epoetin alfa inj. (EPOGEN, PROCRIT) and darbepoetin alfa inj (ARANESP).

☐ Antiemetic; Anti-infective (including antibacterial and antifungal drugs); Antipruritic; Anxiolytic; Excess fluid management; Fluid and electrolyte management (including volume expanders) and Pain management: Drugs in these categories *may* be considered ESRD-related if they are prescribed for conditions that arise secondary to dialysis treatment.

☐ **Is the requested drug being used to treat an ESRD/Dialysis-related condition in a patient diagnosed with ESRD *who currently requires Dialysis*? (ICD 10 Code: N18.6)**

☐ Yes ***[Covered under the ESRD Prospective Payment System (PPS), drug must be supplied by dialysis facility]***

OR ☐ 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?

☐ Indicate diagnosis: _____ 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:

☐ **FOR ARANESP ONLY:** Patient has tried and failed or was intolerant to: epoetin alfa (EPOGEN or PROCRIT)

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: _____

_____

_____

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: _____

_____

_____

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: _____

_____

_____

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