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

Request Information (required)

This request is:

☐ **Expedited* (Urgent)** (decision within 24 hours)

☐ **Standard (Non-Urgent)** (decision within 72 hours)

*If the requestor or prescriber believe that waiting 72 hours for a standard decision could seriously harm the member's life, health, or ability to regain maximum function, an expedited (fast) decision can be requested. If the prescriber indicates that waiting 72 hours could seriously harm the member's health, a decision will automatically be made within 24 hours. If the prescriber's support for an expedited request is not obtained, the request will be reviewed to determine if a fast decision is required.

Please Note: All information below is required to process this request. Any information that is incomplete or illegible will delay the review process. If the request is asking for an EXCEPTION, the prescriber MUST provide a statement supporting the request and the request cannot be processed without one. Please submit all **FORMULARY EXCEPTION** requests on the standard **CMS COVERAGE DETERMINATION** form. Requests that are subject to PRIOR AUTHORIZATION (or any other utilization management requirement), may require supporting information.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber 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:

Requestor Information (required if not requested by the member or prescriber)

An individual other than the member or prescriber (such as a family member or friend) may make a request on behalf of the member provided that the individual is a representative. **Documentation must be attached** showing the individual's authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact the plan or 1-800-Medicare.

Requestor Name:		Requestor Phone:
Requestor Address:		Relationship to Member:
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)
- ☐ prednisolone (ASMALPRED / MILLIPRED / ORAPRED)
- ☐ prednisone (DELTASONE / RAYOS)
- ☐ sirolimus (RAPAMUNE)
- ☐ tacrolimus (ASTAGRAF XL / ENVARSUS XR / HECORIA / PROGRAF)
- ☐ Other: _____

Quantity Prescribed:	Dosage Form:
Strength & Route of Administration:	Directions for Use (including frequency and expected length of therapy):

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 member 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 belatacept (NULOJIX), 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 member 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 member'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 member 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 member 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?

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

Please Note: If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known. 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.

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

Exception Requests (optional)

If the request is not for a prior authorization, please indicate the request type:

The prescriber **MUST** provide a statement supporting the request. Requests cannot be processed without one.

☐ The member has been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from the list during the plan year.

☐ The request is for an exception to the plan's limit on the number of pills (quantity limit) the member can receive so that the member can get the number of pills the prescriber prescribed.

☐ The drug plan charges a higher copayment for the drug the prescriber prescribed than it charges for another drug that treats the member's condition, and the member wants to pay the lower copayment.

☐ The member has been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier.

☐ The drug plan charged the member a higher copayment for a drug than it should have.

☐ The member wants to be reimbursed for a covered prescription drug that they paid for out of pocket.

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 member? ☐ Yes ☐ No (If yes, please explain below)

Is the member currently being treated for the condition(s) requiring the requested drug? ☐ Yes ☐ No

(If yes, please explain the member's current drug regimen for the condition(s) below)

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

Are there any concerns for a drug interaction with the addition of the requested drug to the member's current drug regimen? ☐ Yes ☐ No (If yes, please explain the benefits despite the noted concern and the monitoring plan to ensure safety below)

Are there any FDA noted contraindications to the requested drug? ☐ Yes ☐ No (If yes, please explain the benefits despite the noted concern and the monitoring plan to ensure safety below)

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_____

Submission Information (required)

Signature: _____ **Date:** _____

Please Note:

- This request may be denied or dismissed unless all required information is received.
- The prescriber's office will receive a response via fax.
- For urgent requests, please call the phone number listed below.
- 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.
- Requests can also be initiated via phone or the form may be sent via fax or mail:

Phone Number: (866) 270-3877
Fax Number: (855) 668-8552
Mailing Address: ATTN: PRIOR AUTHORIZATION
P.O. Box 1039
Appleton, WI 54912-1039

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

PLEASE FAX COMPLETED FORM TO: 855-668-8552