

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049

**GENERATIONS HEALTHCARE**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Twinrix®, Engerix-B®, Recombivax®: Prior Authorization Request Form: Please respond.

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- Please complete the attached Twinrix®, Engerix-B®, Recombivax® Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Twinrix®, Engerix-B®, Recombivax®**

Hepatitis B vaccine is covered under Medicare Part B if used in patients at high or intermediate risk of contracting hepatitis.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

# Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Twinrix®, Engerix-B®, Recombivax® Criteria

- 1 Please indicate agent requested:  
 Twinrix®  
 Engerix®  
 Recombivax®
  - 2 Please indicate ICD-9 code supporting the necessity for the requested drug. This question must be completed.  
 ICD-9: \_\_\_\_\_
  - 3 Is the patient at high or intermediate risk of contracting hepatitis? (see list below)  
 Yes  No
    - Direct exposure to hepatitis B (acute exposure to blood containing HBs-Ag or sexual exposure to a HBs-Ag-positive person)
    - End stage renal disease (ESRD)
    - Hemophiliacs who received Factor VIII or IX concentrates
    - Clients of institutions for individuals for the mentally handicapped
    - Persons who live in the same household as a hepatitis B Virus (HBV) carrier
    - Homosexual men
    - Illicit injectable drug abusers
    - Staff in institutions for the mentally handicapped
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work
- If yes, please note Hepatitis B vaccination is covered by Medicare Part B.

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_