

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049



SELECTCARE of TEXAS, L.L.C.

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Infusion Drugs: Prior Authorization Request Form: Please respond.

- Please complete the attached Infusion Drugs 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

Infusion Drugs

The listed infusion drugs are covered under the Medicare Part B DME benefit when used as a supply with an infusion pump in the home. Coverage of the listed infusion drugs under Part D is limited to certain long-term care facilities that do not qualify as a patient's home.

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.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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M0018_PATEMP_1107 CMS 11/28/07 H4506

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.

Infusion Drugs Criteria

1 Please indicate requested drug:

• Formulary Drugs

- | | |
|---|---|
| <input type="checkbox"/> Acyclovir | <input type="checkbox"/> Amphotericin B |
| <input type="checkbox"/> Bleomycin | <input type="checkbox"/> Dopamine |
| <input type="checkbox"/> Foscarnet | <input type="checkbox"/> Ganciclovir |
| <input type="checkbox"/> Hydromorphone | <input type="checkbox"/> Morphine Sulfate |
| <input type="checkbox"/> Novolog | <input type="checkbox"/> Apidra |
| <input type="checkbox"/> Humalog | <input type="checkbox"/> Regular Insulin |
| <input type="checkbox"/> Humulin R U500 | |

• Non-Formulary Drugs

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Adriamycin | <input type="checkbox"/> Ambisome |
| <input type="checkbox"/> Amphotec | <input type="checkbox"/> Cladribine |
| <input type="checkbox"/> Cytarabine | <input type="checkbox"/> Deferoxamine |
| <input type="checkbox"/> Dobutamine | <input type="checkbox"/> Doxorubicin |
| <input type="checkbox"/> Epoprostenol | <input type="checkbox"/> Fentanyl |
| <input type="checkbox"/> Floxuridine | <input type="checkbox"/> Fluoruracil |
| <input type="checkbox"/> FUDR | <input type="checkbox"/> Gallium |
| <input type="checkbox"/> Infumorph | <input type="checkbox"/> Leustatin |
| <input type="checkbox"/> Methadone | <input type="checkbox"/> Milrinone |
| <input type="checkbox"/> Prialta | <input type="checkbox"/> Remodulin |
| <input type="checkbox"/> Vincristine | <input type="checkbox"/> Vinblastine |
| <input type="checkbox"/> Vincasar PFS | <input type="checkbox"/> Trepostinil |

2 Please indicate drug concentration requested

3 Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.

ICD-9 Code: _____

4 Indicate where the patient resides:

- At home OR An assisted living facility OR An intermediate care facility for the mentally retarded (ICF/MR).
- Long term care resident: Hospital or skilled nursing facility bed who does not have part A coverage, whose part A coverage has run out or whose stay is not covered; OR a nursing home that is dually-certified as both a Medicare SNF and a Medicaid SNF; OR A Medicaid-only NF that primarily furnishes skilled care; OR A non-participating nursing home (i.e., neither Medicare or Medicaid) that provides primarily skilled care; OR an institution which has a distinct part SNF which also primarily furnishes skilled care.
- None of the above; please specify location: _____

Medical Justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____