

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



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Pulmozyme® (dornase alfa): Prior Authorization Request Form: Please respond.

- Please complete the attached Pulmozyme® (dornase alfa) 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

Pulmozyme® (dornase alfa)

Pulmozyme is typically covered for treatment of cystic fibrosis under Medicare Part B. Coverage of inhalation solutions under Part D is limited to residents of long-term care facilities.

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

Last Updated: 01/21/2008
S5803_07P0126_v2 (11/2007)

Prior Authorization Request Form



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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.

Pulmozyme® (dornase alfa) Criteria

- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.
 - Cystic fibrosis (ICD-9:277.0)
 - Other (diagnosis and ICD-9) _____
- Is the patient using one of the following recommended nebulizer/compressor systems?
 - Yes No
 - Hudson T Up-draft II® with Pulmo-Aide®
 - Respigard II Nebulizer® (formerly known as Marquest Acorn II®) with Pulmo-Aide®
 - Durable Sidestream® with MOBILAIRE
 - Durable Sidestream® with Porta-Neb®
 - PARI LC Jet+ with PARI PRONEB®
 - PARI BABY® with PARI PRONEB®
- Indicate where the patient resides:
 - At home OR An assisted living facility OR An intermediate care facility for the mentally retarded (ICF/MR).
 - None of the above; please specify location: _____
 - 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.

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

Prescriber's signature: _____ Date: _____