Please complete ALL information below and fax your request to 1-888-671-5285

Medicare Administrative Coverage Determination Request Form for Part B versus D coverage (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

❑ **END STAGE RENAL DISEASE (ESRD) MEDICATION**

Diagnosis and diagnosis code: _____

Is the requested medication contained in one of the following ESRD related drug classes or medication uses: access management, anemia management, anti-infectives, bone and mineral metabolism, and cellular management? ❑ **Yes** ❑ **No**

Does the patient have end-stage renal disease (ESRD)? ❑ **Yes** ❑ **No**

Is the patient on dialysis? ❑ **Yes** ❑ **No**

Is the requested medication being used for an FDA-approved or medically–accepted diagnosis related to dialysis? ❑ **Yes** ❑ **No**

Was the prescription written by any of the following: dentist, chiropractor, gynecologist, ophthalmologist, podiatrist, hospital emergency room prescriber? ❑ **Yes** ❑ **No**

❑ **HEPATITIS B VACCINE**

❑ High or Intermediate Risk, diagnosis code: _____

❑ Other (please provide diagnosis and code): _____

❑ **IMMUNOSUPPRESSANTS**

Diagnosis and diagnosis code: _____

All of the following questions must be answered for patients who underwent transplantation for requests to be processed:

Transplanted organ (specify organ): _____

Date of transplant: _____

Was the patient enrolled in Medicare Part A at the time of the organ transplant? ❑ **Yes** ❑ **No**

❑ **INHALED NEBULIZED SOLUTIONS**

Specify diagnosis and diagnosis code: _____

Is the drug administered using a nebulizer? ❑ **Yes** ❑ **No**

Is the drug administered at home? ❑ **Yes** ❑ **No**

Is the patient in a long-term care facility? ❑ **Yes** ❑ **No**

Medicare Administrative Coverage Determination Request Form for Part B versus D coverage (Page 2 of 2)

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❑ **INSULIN ADMINISTERED VIA AN INSULIN PUMP**

Diagnosis and diagnosis code: _____

Is the drug administered at home? ❑ **Yes** ❑ **No**

Is the patient in a long term care facility? ❑ **Yes** ❑ **No**

Is the insulin administered using an insulin pump? ❑ **Yes** ❑ **No**

❑ **INTRADIALYTIC PARENTERAL NUTRITION (IDPN)/INTRAPERITONEAL NUTRITION (IPN)**

Diagnosis and diagnosis code: _____

Is the pharmacy compounding the IDPN/IPN by adding amino acids to the dialysate solution? ❑ **Yes** ❑ **No**

❑ **INTRAVENOUS IMMUNE GLOBULIN (IVIG)**

❑ Primary immune deficiency, diagnosis code: _____

❑ Other, specify diagnosis and diagnosis code: _____

❑ **ORAL ANTI-EMETIC DRUGS**

Diagnosis and diagnosis code: _____

Is the patient only receiving ORAL chemotherapy? ❑ **Yes** ❑ **No**

Has the drug been ordered by the treating practitioner as part of a cancer chemotherapy regimen? ❑ **Yes** ❑ **No**

Is the drug used as a full therapeutic replacement for an intravenous antiemetic drug that would otherwise have been administered at the time of the chemotherapy treatment? ❑ **Yes** ❑ **No**

Will this oral anti-emetic drug be initiated within two hours of the administration of the chemotherapeutic agent and continued for a period not to exceed 48 hours from that time? ❑ **Yes** ❑ **No**

❑ **ORAL CHEMOTHERAPY AGENTS**

Diagnosis and diagnosis code: _____

Does the requested medication contain the same active ingredient(s) as the non-self-administrable anti-cancer intravenous chemotherapeutic drug? ❑ **Yes** ❑ **No**

Please note: The oral anticancer drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium, or it is a prodrug which, when ingested, is metabolized into the same active ingredient which is found in the non-self-administrable form of the drug

Is the requested medication used for the same anti-cancer chemotherapeutic FDA approved indications, including unlabeled or "off-label" uses, as the non-self-administrable form of the drug? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by a practitioner licensed under state law to prescribe such drugs as anti-cancer chemotherapeutics? ❑ **Yes** ❑ **No**

❑ **PARENTERAL NUTRITION (TPN)**

Does the patient have a permanent dysfunction of the digestive tract? ❑ **Yes** ❑ **No**

❑ **ALL OTHER INTRAVENOUS (IV) MEDICATIONS**

Is the drug given intravenously by infusion? ❑ **Yes** ❑ **No**

Is the drug being administered in a long term care facility? ❑ **Yes** ❑ **No**

Is the drug being given in the home? ❑ **Yes** ❑ **No**

Is the drug being administered via an external infusion pump? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-275-2583 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-275-2583 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-275-2583 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: **您**對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-275-2583 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-275-2583 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-275-2583 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-275-2583 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-275-2583 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس سيقوم (TTY: 711) 1-800-275-2583 عليك سوى الاتصال بنا على . هذه خدمة مجانية شخص ما يتحدث العربية.بمساعدتك

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-275-2583 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-275-2583 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-275-2583 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-275-2583 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-275-2583 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-275-2583 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-275-2583 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-275-2583 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

You can file a grievance in the following ways:

- In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103
- By phone: 1-888-377-3933 (TTY: 711)
- By fax: 215-761-0245
- By email: civilrightscoordinator@1901market.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*