

## MEDICARE PART B vs. D COVERAGE DETERMINATION

**\*\*Please note that this form is to be completed by the prescribing physician.** This form and its contents are permissible under HIPAA, as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment, and healthcare operations (TPO). HIPAA does not restrict the communication of PHI with providers for TPO related purposes.

Date of Request:

Case #:

Member Name:	Date of Birth:
Member ID Number:	Sponsor:
Physician Name:	DEA #:
Physician Phone Number:	Physician Fax Number:

### Medication:

We have received your request for an exception for the patient and medication listed above. ***In order to complete our review and make an appropriate determination for Medicare B vs. D coverage, please indicate all applicable information.***

**Diagnosis:** \_\_\_\_\_ **ICD9 code:** \_\_\_\_\_

Is this a patient at a Long Term Care Facility? YES \_\_\_\_\_ NO \_\_\_\_\_

Is this patient receiving his/her medication by a pump infusion? YES \_\_\_\_\_ NO \_\_\_\_\_

Is this patient on dialysis? YES \_\_\_\_\_ NO \_\_\_\_\_

Is this patient a recipient of an organ transplant? YES \_\_\_\_\_ NO \_\_\_\_\_

If **YES** to organ transplant, was the transplant covered by Medicare Part B?

YES \_\_\_\_\_ NO \_\_\_\_\_ Date of Transplant \_\_\_\_\_

(Note: All medications for recipients of a Medicare Part B covered transplant will have their transplant medications covered under their Medicare Part B Benefit for 36 months.)

### Nutritional Supplements

Does this patient have a functioning G. I. tract? YES \_\_\_\_\_ NO \_\_\_\_\_

Other important information \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*Physician signature field must be completed. Requests will not be reviewed in the event that this field is incomplete.

\*\*Please call (800) 311-0594 for assistance in filling out this form. (Dr. office only). Most requests are processed within one business day of receiving complete information. However, some requests may require more time to review.

**PLEASE FAX ONLY THIS COMPLETED FORM TO PHARMACARE AT (800) 373-0238**