

Medicare Part B vs. Medicare Part D Request Form

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login **OR** covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: <u>888-446-8535</u>

Mail: Blue Cross NC, ATTN: Part D Coverage Determination

P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx

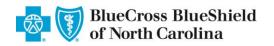
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing						
Prescrib	er Information	Patient Information				
Physician Name:	NPI #:	Patient Name:				
Office Contact Person:		Patient ID #:				
Office Phone #: Office Fax #:		Home Phone #:				
Address:		Sex: □ Female □ Male	Sex: □ Female □ Male			
City:	State: Zip:	DOB:				
	Diagnosis a	nd Medication Information				
Medication Requested:		Diagnosis Code:				
Strength and Route of Adm	nistration:					
	Please a	nswer questions below				
Certain medications may be	covered under Medicare	e Part B or Medicare Part D and therefore, require prior review	to			
		CMS Coverage database https://www.cms.gov/medicare-coverage				
	isdiction C http://www.cg	smedicare.com/jc/coverage/lcdinfo.html for Part B drug covera	ge			
clarification).						
Check the "Yes" box to believes that waiting for	request an expedited revie a decision under the stan m function in serious jeop	ew if the enrollee or his/her physician or other prescriber adard time frame may place the enrollee's life, health, or pardy. A standard review will have a decision made within 72	□ No			
2. Please indicate if the req ☐ brand-name produc						
(medical) benefit (includi	ng "buy-and-bill")?	a healthcare professional and billed under the Part B □ Yes	□ No			
		self-administered by the patient OR billed under the				
		□ Yes	☐ No			
		n of how the requested medication will be billed and				
related to any of the follow A. Chemotherapy i. If YES, ple B. Post-operative C. Medication-ind	wing conditions? -induced nausea/vomiting ase answer question 5 of nausea/vomiting uced nausea/vomiting	□ Yes	□ No			
	<u> </u>	Yes				
		□ Yes	⊔ No			
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5. For oral anti-emetics prescribed for chemotherapy-induced nausea/vomiting, please answer the following questions:	g	
A. Is the patient receiving oral chemotherapy ?		
i. If YES , please answer the following questions:		
a. List the names of all oral chemotherapeutic medications the patient will receive:		
b. Is it likely that the anti-cancer medication will cause vomiting if the requested oral		
anti-emetic is not given?		□ No
c. Will the patient receive the oral anti-emetic within 2 hours before the oral anti-cancer		П N-
medication is given?	. ⊔ Yes	⊔ №
If YES, will the patient take the oral anti-emetic after the oral anti-cancer medication is given?	П Уос	ПМо
B. Is the patient receiving IV chemotherapy?		
i. If YES , please answer the following questions:	. 🗆 163	
a. Will the patient receive the oral anti-emetic within 2 hours of chemotherapy		
administration?	. 🗆 Yes	□ No
1. If YES, will the patient take the oral anti-emetic beyond 48 hours of receiving		
chemotherapy?	. □ Yes	□ No
b. Will the oral anti-emetic be used as a full therapeutic replacement for IV anti-emetic		
medications as part of an IV cancer chemotherapeutic regimen (i.e., patient is not		
receiving an IV anti-emetic)?	. □ Yes	□ No
c. Will the oral anti-emetic be used with other oral anti-emetic medications?	. □ Yes	□ No
1. If YES, please list the names of all oral anti-emetics and IV chemotherapeutic		
medications the patient will receive:		
O le the consent of the Parties and Parties and Parties and		- N.
6. Is the requested medication used in a nebulizer?	. ⊔ Yes	⊔ No
A. If YES, please answer the following questions:	□ Vaa	□Мо
i. Does the patient have a diagnosis of COPD or asthma?	. ⊔ res	□ NO
ii. Is the patient currently in a Skilled Nursing Facility or hospital?	П УΔς	П №
a. If YES , has the patient exhausted all Medicare Part A benefits?		
a. II 123, has the patient exhausted all Medicale Falt A benefits:	. 🗆 163	
7. Is the requested medication an immunosuppressant related to organ transplant?	. □ Yes	□ No
A. If YES, please answer the following questions:		
i. Please indicate the organ transplanted:		
ii. Please provide the date of the transplant:/		
iii. Did Medicare cover the transplant?	. □ Yes	□ No
8. Is the requested medication insulin?	. □ Yes	☐ No
A. If YES, please answer the following questions:		
i. Is the insulin used in an insulin pump?	. □ Yes	□ No
a. If YES, is it a disposable insulin pump (such as Omnipod or V-go)?	. □ Yes	□ No
O to the requested mediantian related to End Store Denal Disease (ESDD)?	□ Voo	□Мо
9. Is the requested medication related to End Stage Renal Disease (ESRD)?		
A. II 1ES, is the patient currently receiving dailysis?	. Li res	LI NO
10. Is the requested medication a vaccination for Hepatitis B (such as Engerix-B or Recombivax)?	ПYes	ПΝο
A. If YES , is the patient at high or intermediate risk of contracting hepatitis B (such as an	. 🗕	
individual with ESRD or hemophilia, or a health care professional)?	. □ Yes	□ No
	00	
11. Is the requested medication a vaccination for Tetanus (such as Tenivac or TDVAX)?	□ Yes	□ No
A. If YES, is the need for a tetanus vaccine related to an injury or direct exposure to tetanus?		
PLEASE CONTINUE TO NEXT PAGE		



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12. Please list the names of all medications (including insulins) previously tried and failed or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to this request:						
13. A	dditional information we should consider (attach any supporting documents):					
I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.						
Phys	ician Signature:	Date:				

Blue Cross and Blue Shield of North Carolina is a HMO/PPO/PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.