Priority Health

Medicare Medical (Part B) Prior Authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Medicare Part B**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

General Part B Drug Request (Non-Oncology)

Member Information

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ______________

Primary Care Physician: ______________________ Gender assigned at birth: ☐ Male ☐ Female

Provider Information

Requesting Provider: ______________________ Phone: ______________ Fax: ______________

Address: ____

NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ______________

Drug and Billing Information *(Please fill out the following information)*

☐ New request ☐ Continuation request - **Original therapy start date**: ______________

Drug product: ______________________ **HCPCS Code:** ______________________

ICD-10 Code(s): ______________

Patient Dosing Information:

Date of last dose (if applicable): ______________ **Total doses/cycles/duration requested:** ________

Date of next dose (if applicable) ______________ **Height:** ______ **Weight:** ______ **BSA:** ______

Dose: ______________________ **Dose Frequency**: ______________________

Place of Administration:

☐ Patient self-administration

☐ Physician's office

☐ Outpatient Hospital Facility: ______________ NPI: ______________ Fax: ______________

☐ Outpatient Infusion Facility: ______________ NPI: ______________ Fax: ______________

☐ Home Infusion Facility: ______________ NPI: ______________ Fax: ______________

☐ Other (specify): ______________________

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Patient to acquire from pharmacy

☐ Physician to acquire from specialty pharmacy and specialty pharmacy to bill:

Specialty Pharmacy: ______________ NPI: ______________ Fax: ______________

All fields must be complete and legible for review. Your office will receive a response via fax.

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Last reviewed 11/2024

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Precertification Requirements

Before this drug is covered, the patient must meet certain criteria. Follow the below steps for coverage criteria:

1. Check for applicable Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other Medicare guidance using the Medicare Coverage Database at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.[1]
2. Check for additional Priority Health Medicare coverage criteria using the Medical Benefit Drug List (MBDL).
3. For new-to-market drugs not yet reviewed by the Priority Health Pharmacy and Therapeutics (P&T) Committee, the following criteria are required:
   1. Use of the drug for a Medically Accepted Indication[2] – and –
   2. Use of all appropriate alternative covered Part D drugs (for plans with prescription drug coverage) and Part B drugs with evidence-based support for the requested indication.
4. For all requests, medical records supporting the request must be provided.

National and Local Coverage Determination and Article (NCD, LCD, and LCA) Criteria[1]

Priority Health complies with NCDs, LCDs, LCAs, and general coverage and benefit conditions included in Traditional Medicare law for Part B drugs. Use the Medicare Coverage Database (MCD) to review applicable coverage policies for the requested drug based on your jurisdiction: https://www.cms.gov/medicare-coverage-database/search.aspx.

LCD and LCA criteria are established by the Medicare Administrative Contractor (MAC) based on the state or other jurisdiction. MACs for the state of Michigan:

Claim/Drug Type	Jurisdiction	MAC
Part A, Part B	Jurisdiction 8	Wisconsin Physicians Service (WPS) Government Health Administrators
Durable Medical Equipment (DME)	Jurisdiction B	CGS Administrators
Home Health and Hospice (HH + H)	Jurisdiction 6	National Government Services (NGS)

Providers are responsible for reviewing applicable coverage policies. Priority Health attempts to provide as much guidance as possible; however, if there is a conflict between this document and any Medicare coverage guidance, the Medicare coverage guidance will supersede.

Medically accepted indication[2]

If no NCD, LCD, or LCA criteria are available for the state or jurisdiction in which the member is receiving services, Priority Health Medicare creates coverage criteria based on CMS-approved compendium and current evidence in widely used treatment guidelines or clinical literature. This includes a review for a Food and Drug Administration (FDA) - Approved or medically accepted indication, defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

Additional Information

1. When criteria are met, coverage duration will be up to 2 years, as medically necessary. Dose will be approved according to the Food and Drug Administration (FDA)-approved labeling or within accepted standards of medical practice.
2. Authorization for indications not approved by the FDA or recognized in Medicare-approved compendia (e.g., DrugDex, AHFS, Lexi-Drugs, Clinical Pharmacology) require supporting evidence for coverage. Please provide published peer-reviewed literature supporting the drug's use for the individual member case.
3. For Part B oncology drugs, refer to the Medicare Part B Oncology Prior Authorization form and the Medical Benefit Drug List available at priorityhealth.com.

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Precertification Documentation

A. What condition is this drug being requested for?

____

B. Is this a cancer therapy?

☐ Yes. Refer to the Medicare Part B Oncology Prior Authorization form to ensure all necessary information is provided for a timely review.

☐ No. *Continue through the questions.*

C. Have you reviewed the Medical Benefit Drug List **to see if this drug has Step Therapy and/or other prior authorization requirements?**

☐ Yes. *Continue through the questions.*

☐ No. Refer to the Medical Benefit Drug List to ensure all necessary information is provided for a timely review

D. Explain the medical reason for this request:

____

____

E. List previous drugs the patient tried. (List the name, date prescribed, and any other important information.)

Drug	Dose	Dates	Outcome

F. Provide any additional information for consideration (optional)**:**

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