



Prior Authorization Form

Medicare Administrative Prior authorization for Part B/D coverage

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Date: Patient ID#: DOB:
Patient Name: Provider NPI:
Prescribing Physician: Office Contact:
Office Fax #: Office Phone:

HEPATITIS B VACCINE
High or Intermediate Risk, diagnosis code:
Other (please provide diagnosis and code):

PARENTERAL NUTRITION (TPN) (Drug requested)
Does the patient have a permanent dysfunction of the digestive tract? Yes No

ALL OTHER INTRAVENOUS (IV) (Drug requested)
Is the requested drug administered in the home setting via an external infusion pump? Yes No

ORAL CHEMOTHERAPY AGENTS (Drug requested)
Diagnosis and code

INTRAVENOUS IMMUNE GLOBULIN (IVIG)
Primary Immunodeficiency, diagnosis code:
Other, diagnosis and code:

NEBULIZED SOLUTIONS (Please circle drug): acetylcysteine (Mucomyst), albuterol (Accuneb, Proventil), cromolyn (Intal), DuoNeb, ipratropium, metaproterenol (Alupent), Pulmicort Respules, Pulmozyme, TOBI, Xopenex
For use in a nebulizer
Other, diagnosis and code:

IMMUNOSUPPRESSANTS (Please circle drug): Cellcept, Imuran, cyclosporine (Neoral, Sandimmune, Gengraf), Rapamune, and Prograf
Transplanted organ (specify)
Transplant, date of transplant:
Transplant paid by Medicare? Yes No
Other, diagnosis and code:

ERYTHROPOIETIN (Please circle drug): Aranesp, Epogen, Procrit
Anemia with Chronic Renal Failure, diagnosis code:
Is member currently of Dialysis? Yes No
Other, diagnosis and code:

Pending approval deliver to: Physician's office Member's home Office supply (NO AUTH REQUIRED)

Please add any other supporting medical information that may be useful in the decision making process:

FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL