Prior Authorization Form

ESRD Prior authorization for Part B/D coverage

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:______________________________
(one drug per form only)

Date: ________________________ Patient ID#: _______________ DOB:__________

Patient Name: _____________________________ Provider NPI: _____________________________

Prescribing Physician: ________________________ Office Contact: ____________________________

Office Fax #: _____________________________ Office Phone: _____________________________

1. **DIAGNOSIS FOR DRUG REQUESTED: _________________________**

2. **Is member currently on Dialysis?** ☐ **YES** ☐ **NO**

   Dialysis Start Date: _____________ (mm/dd/yy)

   Dialysis End Date: ________________(mm/dd/yy)

3. **Is the drug prescribed to be used for an ESRD related condition?** ☐ **YES** ☐ **NO**

   REASON FOR ADMINISTRATION OF DRUG (*must check one*):
   ☐ **Access Management : drug being used to ensure access by removing clots from grafts, reverse anticoagulation if too much medication is given, and provide anesthetic for access placement**
   ☐ **Anemia Management: drug used to stimulate red blood cell production and/or treat or prevent anemia**
   ☐ **Anti-Infectives: (Vancomycin IV and Cubicin IV (Daptomycin) Only)**
   ☐ **Bone and Mineral Metabolism: drug used to prevent bone disease secondary to Dialysis**
   ☐ **Cellular Management: drug used for deficiencies of naturally occurring substances**

4. **Does Prescriber receive a monthly capitation payment to manage ESRD beneficiaries care?**
   ☐ **YES** ☐ **NO**

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@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL