PriorityHealth

Pharmacy Part B vs. Part D determination form

Fax completed form to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☐ **Medicare Part B** ☐ **Medicare Part D**

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.

Azathioprine

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☒ Azathioprine 50 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Coverage determination criteria

This drug requires prior authorization and may be covered differently under Medicare Part B (medical services) or D (prescription drug coverage) depending on the patient's circumstances. To determine which benefit the drug is covered under, Priority Health Medicare needs to know the use and setting of the drug.

What condition is the drug being used for?

- ☐ Actinic dermatitis
- ☐ Ankylosing spondylitis
- ☐ Atopic dermatitis
- ☐ Bullous pemphigoid with psoriasis
- ☐ Corneal transplant
- ☐ Duchenne muscular dystrophy
- ☐ Erythema multiforme
- ☐ Giant cell myocarditis
- ☐ Henoch-Schonlein nephritis
- ☐ Idiopathic pulmonary fibrosis
- ☐ Inflammatory bowel disease
- ☐ Kidney transplant
- ☐ Lichen planus
- ☐ Liver transplant
- ☐ Lymphocytic hypopituitarism
- ☐ Multiple sclerosis
- ☐ Myasthenia gravis
- ☐ Nephrotic syndrome
- ☐ Neuromyelitis optica
- ☐ Pancreas transplant
- ☐ Pemphigus vulgaris
- ☐ Polymyositis
- ☐ Prurigo nodularis
- ☐ Radiation pneumonitis
- ☐ Retractile mesenteritis
- ☐ Rheumatoid arthritis
- ☐ Sprue
- ☐ Systemic lupus erythematosus
- ☐ Takayasu's disease
- ☐ Vasculitis
- ☐ *Other – the patient's condition is*: _____

If applicable, was the member eligible for Medicare Part A at the time of transplant? ☐ Yes ☐ No

If applicable, what was the date of the patient's transplant? _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2017

Last reviewed 11/2018

Additional information

When this drug is not covered under Medicare Part B, it is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* – supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

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Last reviewed 11/2018