Priority Health Medicare prior authorization 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: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Digox® (digoxin) 250 mcg (0.25 mg)

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: _____

Drug information

☐ New request ☐ Continuation request

Drug product: ☐ Digox® 0.25 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
2. For patients ≥ 65 ***AND***
   a. A diagnosis of atrial fibrillation: Digox® 250 mcg is covered (no additional criteria to be met)
   b. A diagnosis of heart failure: Provider must attest to consideration of the benefit–risk ratio for digoxin doses exceeding 0.125mg per day
3. For patients < 65: Digox® 250 mcg is covered for both atrial fibrillation and heart failure

The American Geriatric Society (AGS) classified digoxin as a high risk medication when used in persons age 65 and older at doses exceeding 0.125 mg each day. AGS recommends limiting the use of digoxin in the elderly to treatment of atrial fibrillation (do not use for heart failure).

Additional information

Note: When criteria are met, duration of approval will be 1 year.

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

Updated 01/2019
Last reviewed 05/2019

Medically accepted indication*

This drug 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.)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Atrial fibrillation
☐ Heart failure

For patients, ≥ 65, do the benefits of the 0.25 mg dose outweigh the adverse risks?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____
☐ No

☐ *Other – the patient's condition is:* _____
Rationale for Other use: _____

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Digox® likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Digox®, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Updated 01/2019
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