

Medicare 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.

Aranesp[®] (darbepoetin alfa)

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

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Drug product:

☐ Aranesp vial

☐ Aranesp prefilled syringe

Dosing frequency: _____

Part B vs. Part D Coverage Determination Criteria

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

For this drug to be covered under Medicare Part B, the following criteria must be met:

1. Must be used for the treatment of anemia; and
2. Must have chronic kidney disease (CKD); and
3. Must be on dialysis

For this drug to be covered under Medicare Part D, the patient must meet the following criteria:

1. Must not meet criteria for Medicare Part B coverage (*see above*)
2. Must be used for a medically accepted indication*

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, DRUGDEX Information System, and Lexi-Drugs)

Precertification Documentation

A. What condition is this drug being requested for?

☐ Anemia caused by chemotherapy

1. Does the patient have a non-myeloid malignancy?

☐ Yes

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

☐ Yes. *Rationale for exception:* _____

☐ No

2. Will the patient receive at least 2 additional months of planned chemotherapy?

☐ Yes

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

☐ Yes. *Rationale for exception:* _____

☐ No

☐ Anemia caused by chronic kidney disease

1. Is the patient receiving renal dialysis services? ☐ Yes ☐ No

☐ Other – the patient's condition is: _____

Rationale for Other use: _____

Additional information

Note: Criteria is found in the Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), section 50.5.2 (Erythropoietin (EPO))

Priority Health Medicare Part D 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 Aranesp likely be the most effective option for this patient?

☐ No

☐ Yes, because: _____

If the patient is currently using Aranesp, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No

☐ Yes, because: _____
