PriorityHealth

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.

Granisetron oral

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: ☐ granisetron oral tablet

Dosing frequency: _____

Part B vs. Part D Coverage Determination Criteria

This drug requires prior authorization because it may be covered differently under 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 patient must meet the following criteria:

1. Must be used for the prevention of chemotherapy-induced nausea and vomiting;
2. Must be administered within 2 hours of chemotherapy and continued no more than 48 hours after chemotherapy; and
3. Must be used as a full therapeutic replacement for intravenous (IV) anti-emetic drugs that would have otherwise been administered at the time of chemotherapy.

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*

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

No changes made since 09/2018
Last reviewed 07/2020

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)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Prevention of chemotherapy-induced nausea and vomiting

1. **Will granisetron oral be administered within 2 hours of chemotherapy?**
   ☐ Yes
   ☐ No
2. **Will granisetron oral be continued for more than 48 hours after chemotherapy?**
   ☐ Yes
   ☐ No
3. **Will granisetron oral be used as a full therapeutic replacement for IV anti-emetic drugs that would have otherwise been administered at the time of chemotherapy?**
   ☐ Yes
   ☐ No

☐ Prevention of postoperative nausea and vomiting
☐ Prevention of radiation-induced nausea and vomiting

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

Additional information

Note: Criteria are found in the Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), section 50.5.4 (Oral Anti-Nausea (Anti-Emetic) Drugs)

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

Created 08/2020
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Last reviewed 01/2021

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 granisetron oral likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using granisetron oral, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

_____

_____

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

Created 08/2020
No changes made since 01/2021
Last reviewed 01/2021