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.

Nebupent® (pentamidine isethionate)

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 and Billing Information

☐ New request ☐ Continuation request

Drug product: ☐ Nebupent 300 mg inhalation soln.

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____
Will Nebupent be used in a nebulizer? ☐ Yes ☐ No

Place of administration:
☐ Home
☐ Long term care facility
☐ Other: _____

Note: Nebupent is covered under Medicare Part B when used with a nebulizer in the patient's home.

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.

1. Must be using Nebupent for a medically accepted indication* not otherwise excluded from Part D.
    a. For prophylaxis of pneumocystis pneumonia due to HIV infection and patient meets following criteria:
        i. Age 30 days to 1 year
            1. Patient was born to a mother known to be HIV positive
        ii. Age 1 to 2 years
            1. Patient has experienced at least one episode of pneumocystis pneumonia
        iii. Submit most recent CD4+ lymphocyte count
    b. For prophylaxis or treatment of pneumocystis pneumonia:
        i. Must have a documented therapeutic trial with trimethoprim/sulfamethoxazole (generic Bactrim or Septra)

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 12/2017
Last reviewed 01/2019

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?

- ☐ Treatment of active pneumocystis pneumonia infection
- ☐ Prophylaxis of pneumocystis pneumonia due to HIV infection
- ☐ *Other, the patient's condition is:* _____

B. Which of the following, if any, apply to the patient?

- ☐ Patient was born to a mother known to be HIV positive
- ☐ Patient has experienced one or more episodes of pneumocystis pneumonia

C. Has the patient had a documented trial with sulfamethoxazole/trimethoprim (generic Bactrim or Septra)?

- ☐ Yes
- ☐ No – rationale for use: _____

D. What is the patient's CD4+ lymphocyte count? _____

Priority Health Medicare plans

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

Priority Health Medicare exception request

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 Nebupent likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

_____

_____

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

- ☐ No
- ☐ Yes, because: _____

_____

_____

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Updated 12/2017
Last reviewed 01/2019