

Medicare Part B Prior Authorization/Step Therapy Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: **Medicare Part B**
 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.

Glycopeptide Antibiotics (IV)

Member Information

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____

Provider Information

Requesting Provider: _____ Phone: _____ Fax: _____
 Address: _____
 NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Drug and Billing Information *(Please fill out the following information)*

New request Continuation request - **Original therapy start date:** _____

Drug Product: Dalvance vial Vibativ vial Orbactiv vial Kimyrsa vial

Patient Dosing Information:

Date of last dose (if applicable): _____ **Total doses/cycles/duration requested:** _____
Date of next dose (if applicable) _____ **Height:** _____ **Weight:** _____ **BSA:** _____
Dose: _____ **Dose Frequency:** _____

Place of Administration:

Patient self-administration
 Physician's office
 Outpatient infusion Facility: _____ NPI: _____ Fax: _____
 Home infusion Agency: _____ NPI: _____ Fax: _____
 Other (specify): _____

Billing:

Physician to buy and bill
 Facility to buy and bill
 Specialty Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis Code(s): _____ **HCPCS Code:** _____

Precertification Requirements

Step therapy (trial with the below listed drug[s]) is only applicable to members who are enrolled in a Medicare Advantage Prescription Drug (MAPD) plan and will not apply to members who are actively receiving treatment with the non-preferred drug (have a paid drug claim within the past 365 days).

Before this drug is covered, the patient must meet the following:

1. Must be used for a medically accepted indication¹ and/or follow applicable NCD, LCD or LCA requirements.²
2. Must provide culture and sensitivity results. If not available, must specify the suspected organism(s) being treated.
3. Must try all other susceptible antibiotics (e.g., vancomycin) as determined by culture and sensitivity or as indicated for empiric therapy (e.g., beta-lactam, macrolide, fluoroquinolone).
4. Prescriber must be an infectious disease specialist or have consulted with an infectious disease specialist.

¹See *NCD, LCD, and LCA* section below

²See *Medically accepted indication* section below

Additional information

- When criteria are met, dose will be approved according to the FDA-approved labeling or within accepted standards of medical practice.
- Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g., DrugDex, AHFS, Lexi-Drugs, and Clinical Pharmacology) require supporting evidence for coverage. Please provide published peer-reviewed literature supporting the drug's use for this individual patient case.

National and Local Coverage Determination/Article (NCD, LCD, and LCA) Criteria¹

Priority Health applies Medicare NCD, LCD, and LCA criteria for Part B drugs. The following apply to Glycopeptides: **N/A**

Medically accepted indication²

If no NCD, LCD, or LCA criteria are available for the state in which the member is receiving services, Medicare Part B drugs will be reviewed for a medically accepted indication, defined in the Medicare Benefit Policy Manual Chapter 15 § 50:

A medically accepted indication for a drug that is not a part of an anti-cancer regimen is a use that is:

- 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 references, taking into consideration the major drug compendia (e.g. American Hospital Formulary Service-Drug Information, Micromedex DrugDex, Lexi-Drugs), authoritative medical literature, and/or accepted standards of medical practice.

Precertification Documentation

A. What condition is this drug being requested for?

- Acute bacterial skin and skin structure infection (ABSSSI) caused by susceptible organisms
- Other: _____

Rationale for Other use: _____

B. What are the known or suspected organism(s) being treated?

- Methicillin-susceptible Staphylococcus aureus (MSSA)
- Methicillin-resistant Staphylococcus aureus (MRSA)
- Streptococcus pyogenes
- Streptococcus agalactiae
- Streptococcus anginosus group (including S. anginosus, S. intermedius, S. constellatus)
- Enterococcus faecalis (vancomycin susceptible strains)
- Other: _____

C. Was a culture completed?

- Yes.
- No. **Are you requesting an exception to the criteria?**
 - Yes. **Rationale for exception:** _____
 - No

D. Was antibiotic susceptibility determined?

- Yes.
- No. **Are you requesting an exception to the criteria?**
 - Yes. **Rationale for exception:** _____
 - No

5. Has the patient tried and failed all other susceptible antibiotics as determined by culture and sensitivity or as indicated for empiric therapy? Fail is defined as an intolerance or inability to improve the condition.

- Yes. **Please list all antibiotics tried for the infection:**

Drug _____	Date _____
Drug _____	Date _____
Drug _____	Date _____
Drug _____	Date _____

- No. **Are you asking for an exception to this requirement?**
 - Yes. **Rationale for exception:** _____
 - No.

6. Is the prescriber an infectious disease specialist or has one been consulted for this request?

- Yes.
- No. **Are you requesting an exception to the criteria?**
 - Yes. **Rationale for exception:** _____
 - No

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 the requested IV Glycopeptide Antibiotic likely be the most effective option for this patient?

No

Yes, because: _____

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

No

Yes, because: _____

