Priority Health

Medicare Part B vs. Medicare Part D 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: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time (72 hours for initial coverage requests and 7 calendar days for appeals) may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Part B vs Part D Drug Request

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: _____ **HCPCS Code:** _____

ICD-10 Code(s): _____

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 Hospital Facility: _____NPI: _____ Fax:_____

☐ Outpatient Infusion Facility: _____NPI: _____ Fax:_____

☐ Home Infusion Facility: _____NPI: _____ Fax:_____

☐ Other (specify): _____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Patient to acquire from pharmacy

☐ Physician to acquire from specialty pharmacy and specialty pharmacy to bill:

Specialty Pharmacy: _____ NPI: _____ Fax:_____

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

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Precertification Requirements

Certain drugs may be covered under Medicare Part B (medical) or Medicare Part D (pharmacy) depending on the use of the drug, the administration, and/or other factors. The benefit responsible for coverage must be determined, as well as any applicable coverage criteria under that benefit must be met, prior to coverage of the drug.

Before this drug is covered, follow the below steps to determine the benefit and any applicable coverage criteria:

1. Use the table below to determine the benefit (Part B or Part D) responsible for drug coverage.
2. **For Part B benefit determinations**: Check for additional coverage criteria using the below resources:
   a. Check for applicable Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other Medicare guidance using the Medicare Coverage Database at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.
   b. Check for applicable Priority Health Medicare medical coverage criteria on the Medical Benefit Drug List (MBDL).
3. **For Part D benefit determinations**: Check for formulary coverage and criteria using the Approved Drug List.
4. For all requests, the drug must be used for a medically accepted indication – AND –
5. For all requests, medical records supporting the request must be provided.

Part B vs. Part D Benefit Determination Table

☐ **Oral anti-emetic (ex: ondansetron, aprepitant, dronabinol, granisetron)**	
Part B vs Part D Determination Question(s)	**A. Is the drug being used to treat chemotherapy-induced nausea/vomiting?** ☐ Yes ☐ No **B. Will the drug be administered within 2 hours of chemotherapy?** ☐ Yes ☐ No **C. Will the drug be administered more than 48 hours after chemotherapy?** ☐ Yes ☐ No **D. Will the drug be used as a full therapeutic replacement for IV anti-emetic drugs that would have otherwise been used?** ☐ Yes ☐ No
Part B Benefit Requirements	1. Used for prevention of chemotherapy-induced nausea and vomiting; and 2. Full therapeutic replacement for IV anti-emetic drugs that would have been used; and 3. Administered within 2 hours of chemotherapy; and 4. Continued for no more than 48 hours after chemotherapy. 5. Part B requirements are not met when the chemotherapy drug is an oral drug or when the chemotherapy drug is given intravenously in the home because the type and dosage of chemotherapy drugs administered in these situations do not require intravenous antiemetic drugs. Additional requirements may apply (e.g., NK-1 antagonists). Refer to applicable Medicare guidance including Chapter 15 of the Medicare Benefit Policy Manual and LCD L33827: Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics).
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.

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☐ **Oral chemotherapy with an IV counterpart (ex: capecitabine, methotrexate, cyclophosphamide, Xeloda, Trexall)**	
Part B vs Part D Determination Question(s)	**A. Is the drug being used for cancer?** ☐ Yes ☐ No
Part B Benefit Requirements	1. Oral chemotherapy drugs used for the treatment of cancer provided they have the same active ingredients and are used for the same indications as their injectable version.
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Inhalation solutions (ex: acetylcysteine, albuterol nebulizer solution, albuterol/ipratropium, arformoterol, budesonide solution, pentamidine isethionate, Pulmozyme, tobramycin for inhalation)**	
Part B vs Part D Determination Question(s)	**A. Is the drug being delivered via durable medical equipment or DME (nebulizer)?** ☐ Yes ☐ No **B. Where will the drug be administered?** ☐ Home ☐ LTC ☐ Other: _____
Part B Benefit Requirements	1. Drug delivered via DME in the home. Long-term care (LTC) is not considered the patient's home.
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Immunosuppressants (ex: tacrolimus, cyclosporine, azathioprine, mycophenolate, Nulojix)**	
Part B vs Part D Determination Question(s)	**A. Did the member have a Medicare-covered organ transplant and/or had Medicare at time of transplant?** ☐ Yes ☐ No **B. Date of member enrollment into Medicare Part A:** _____ **C. Transplant date:** _____
Part B Benefit Requirements	1. Immunosuppressant used for a Medicare-covered organ transplant.
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.

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☐ Erythropoietin (EPO) agents (ex: Procrit, Epogen, Aranesp, Retacrit)	
Part B vs Part D Determination Question(s)	**A. Is the drug being used for the treatment of anemia in a member with End-Stage Renal Disease (ESRD) on dialysis?** **☐ Yes ☐ No** **B. What is the member's current hemoglobin or hematocrit level?** **Hgb: _____ g/dL Date: _____** **Hct: _____% Date: _____**
Part B Benefit Requirements	1. EPO is used for the treatment of anemia for members with ESRD on dialysis. EPO is covered under the bundled payment made to the dialysis facility and is not separately payable under Part B. – OR – 2. The above ESRD requirements are not met, and EPO is given incident to a physician's service (e.g., buy/bill). Ensure review of applicable coverage criteria including the following Medicare guidance: • LCD L34633: Erythropoiesis Stimulating Agents (ESAs) • LCA A56795 Billing and Coding: Erythropoiesis Stimulating Agents (ESAs); and • NCD 110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Non-Erythropoietin (EPO) drugs for End Stage Renal Disease (ESRD) (ex: cinacalcet, calcitriol oral)**	
Part B vs Part D Determination Question(s)	**A. Is the drug being used for a member with ESRD?** **☐ Yes ☐ No** **B. Is the member receiving dialysis services?** **☐ Yes ☐ No**
Part B Benefit Requirements	1. Drug used for a member with ESRD receiving dialysis. It is covered under the ESRD bundled payment made to the dialysis facility and not separately payable under Part B.
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Insulin and drugs administered via infusion pump (ex: Radicava, Empaveli, SCIG)**	
Part B vs Part D Determination Question(s)	**A. Is the drug given via durable medical equipment or DME (i.e., infusion pump)?** ☐ Yes ☐ No **B. Where will the drug be administered?** ☐ Home ☐ LTC ☐ Other: _____

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Part B Benefit Requirements	1. Drug delivered via DME (infusion pump) in the home. Long-term care (LTC) is not considered the patient's home. – OR – 2. Given incident to a physician's service (e.g., buy and bill)
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Parenteral nutrition (ex: TPN, amino acid solutions, amino acid with electrolytes, lipid emulsions)**	
Part B vs Part D Determination Question(s)	**A. Does the member have non-functioning digestive tract?** ☐ Yes ☐ No
Part B Benefit Requirements	1. Drug used in a member with a non-functioning digestive tract.
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Intravenous Immune Globulins (IVIG)**	
Part B vs Part D Determination Question(s)	**A. Does the member have a primary immune deficiency disease?** ☐ Yes ☐ No **B. Is IVIG being administered in the home?** ☐ Yes ☐ No
Part B Benefit Requirements	1. IVIG given in the home for primary immune deficiency disease. – OR – 2. IVIG given incident to a physician's service (e.g., buy/bill). Ensure review of applicable coverage criteria including Medicare LCD L34771 - Immune Globulins.
Part D Benefit Requirements	1. IVIG given in the home for a non-primary immune deficiency disease; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Hepatitis B vaccines (ex: Engerix-B, Recombivax HB)**	
Part B vs Part D Determination Question(s)	**A. Is the member at high or intermediate risk of contracting Hepatitis B?** ☐ Yes ☐ No High or intermediate risk is defined as: • Member with end-stage renal disease (ESRD) • Hemophiliac receiving Factor VIII or IX concentrates • Client or staff of an institution for the mentally handicapped • Living in the same household as a Hepatitis B Virus (HBV) carrier • Men who have sex with other men • Illicit injectable drug abuser • Member diagnosed with diabetes mellitus Health care worker in frequent contact with blood or blood-derived body fluids during routine work

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Part B Benefit Requirements	1. Members at high or intermediate risk of contracting hepatitis B defined above.
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.
☐ **Other (non-hepatitis B) vaccines (ex: Jynneos)**	
Part B vs Part D Determination Question(s)	**A. Is the vaccine being administered for the treatment of an injury or exposure to a disease?** ☐ Yes ☐ No
Part B Benefit Requirements	1. Vaccination is directly related to the treatment of an injury or direct exposure to a disease or condition – OR – 2. The vaccine is one of the following: influenza, pneumococcal, or COVID-19.
Part D Benefit Requirements	1. Does not meet Part B Benefit Requirements; and 2. Use is for a medically accepted indication not otherwise excluded under Part D.

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

Priority Health complies with NCDs, LCDs, LCAs, and general coverage and benefit conditions included in Traditional Medicare law for Part B drugs. Use the Medicare Coverage Database (MCD) to review applicable coverage policies for the requested drug based on your jurisdiction: https://www.cms.gov/medicare-coverage-database/search.aspx.

LCD and LCA criteria are established by Medicare Administrative Contractors (MACs) based on the state or other jurisdiction. MACs for the state of Michigan:

Claim/Drug Type	Jurisdiction	MAC
Part A, Part B	Jurisdiction 8	Wisconsin Physicians Service (WPS) Government Health Administrators
Durable Medical Equipment (DME)	Jurisdiction B	CGS Administrators
Home Health and Hospice (HH + H)	Jurisdiction 6	National Government Services (NGS)

Providers are responsible for reviewing appropriate NCDs, LCDs, LCAs or other Medicare guidance. Priority Health attempts to provide as much guidance as possible; however, if there is a conflict between this document and any Medicare guidance, the Medicare guidance will supersede.

Medically accepted indication

Medically accepted indications (MAIs) are defined by the Centers for Medicare and Medicaid Services (CMS) and depend on the benefit (Part D versus Part B) and whether the drug is used in an anti-cancer regimen.

For Part D: Refer to the Medicare Prescription Drug Benefit Manual Chapter 6, §10.6 – Medically Accepted Indication.

For Part B: If no NCD, LCD, LCA or other coverage policies exist, Part B drugs will be reviewed for a medically accepted indication. Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.2 – Unlabeled Use of Drug.

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Additional information

1. When criteria are met, coverage duration is 12 months with the following exceptions:
    - Part D approvals for oral anti-emetic drugs for post-operative nausea and vomiting: 1 month
    - Part B or Part D approvals for B vs D vaccines (ex: hepatitis B, RSV, monkeypox, etc.) will be granted through the end of the plan year.

2. Doses will be approved as long as medically necessary and in accordance with the drug's approved quantity limits, FDA-approved labeling or within accepted standards of medical practice.

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