TUFTS Health Plan Medicare Preferred

TUFTS Health Plan Senior Care Options

Coverage Determination and Prior Authorization Request for Medicare **Part B vs. Part D**

This form is for physicians to submit information to Tufts Health Plan to help determine drug coverage and proper payment under Medicare Part B vs. Part D per the Centers for Medicare and Medicaid Services (CMS).

- If you check **YES** to the question about the drug, the drug may be paid for by Medicare **Part B** for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (HMO SNP) members. ***For Tufts Medicare Preferred PDP members, please contact the member's medical carrier for coverage details***.
- If you check **NO** to the question about the drug, the drug may be paid for by Medicare **Part D**.

Does the member's condition require Expedited Review [24 Hours]? ☐ **Yes*** ☐ **No**

**By checking this box, I certify that the 72-hour standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.*

Please fax or mail this completed form to: (617) 673-0956 or 705 Mount Auburn Street, Watertown, MA 02472

PATIENT INFORMATION	**PRESCRIBER INFORMATION**
Name: _____ Date:_____	Name: _____ Specialty:_____
DOB: _____ Member THP ID: _____	Provider ID: _____ Phone: _____
Drug Requested:_____ Strength: _____	Fax: _____ Office Contact: _____
Dose: _____ Dosage Form: _____	**Prescriber Signature (required)**:_____

Hepatitis B Vaccine: Engerix B, Recombivax HB		
Is this member at intermediate to high risk of contracting Hepatitis B? (High/Intermediate risk defined as: ESRD patients, Hemophiliacs receiving Factor VIII or IX, clients or staff of an institution for the developmentally disabled, HIV positive patients, persons who live in the same household as a Hepatitis B Virus (HBV) carrier, men who have sex with other men, illicit injectable drug abusers, health care professionals with frequent contact with blood or blood-derived bodily fluids during routine work)	☐ Yes	☐ No
Immunosuppressants: azathioprine, Cellcept, cyclosporine, Gengraf, mycophenolate, Myfortic, Neoral, Prograf, Rapamune, Sandimmune, tacrolimus, Zortress		
Did this member have a Medicare-paid transplant and/or had Medicare at time of transplant?	☐ Yes	☐ No
Oral Antiemetics: Aloxi, Anzemet, Cesamet, dronabinol, Emend, Granisol, granisetron, Kytril, ondansetron, Sancuso, Zofran		
Is this drug being used to treat chemotherapy-induced nausea and vomiting as a full replacement for IV administration within 48 hours of cancer treatment?	☐ Yes	☐ No
Oral Chemotherapy: Alkeran, cyclophosphamide, Cytoxan, etoposide, methotrexate, Myleran, Rheumatrex, Trexall		
Is this drug being used to treat cancer?	☐ Yes	☐ No
Parenteral Nutrition–Amino Acid & Lipids: amino acid solutions, amino acid with electrolyte and/or calcium solutions, IV lipid emulsion		
Does this member have a "permanently" non-functioning digestive tract? (This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration (at least 3 months), the test of permanence is considered met.)	☐ Yes	☐ No

Provider Relations