FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Medicare Administrative Coverage Determination Request Form for Part B versus D coverage (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

❑ **END STAGE RENAL DISEASE (ESRD) MEDICATION**

Diagnosis and diagnosis code: _____

Is the requested medication contained in one of the following ESRD related drug classes or medication uses: access management, anemia management, anti-infectives, bone and mineral metabolism, and cellular management? ❑ **Yes** ❑ **No**

Does the patient have end-stage renal disease (ESRD)? ❑ **Yes** ❑ **No**

Is the patient on dialysis? ❑ **Yes** ❑ **No**

Is the requested medication being used for an FDA-approved or medically –accepted diagnosis related to dialysis? ❑ **Yes** ❑ **No**

Was the prescription written by any of the following: dentist, chiropractor, gynecologist, ophthalmologist, podiatrist, hospital emergency room prescriber? ❑ **Yes** ❑ **No**

❑ **HEPATITIS B VACCINE**

❑ High or Intermediate Risk, diagnosis code: _____

❑ Other (please provide diagnosis and code): _____

❑ **IMMUNOSUPPRESSANTS**

Diagnosis and diagnosis code: _____

All of the following questions must be answered for patients who underwent transplantation for requests to be processed:

Transplanted organ (specify organ): _____

Date of transplant: _____

Has the patient had a transplant from a Medicare approved facility? ❑ **Yes** ❑ **No**

Was the patient eligible for Medicare part A at time of transplant? ❑ **Yes** ❑ **No**

❑ **INHALED NEBULIZED SOLUTIONS**

Specify diagnosis and diagnosis code: _____

Is the medication being used with a nebulizer? ❑ **Yes** ❑ **No**

Is the medication being used with a metered dose inhaler? ❑ **Yes** ❑ **No**

Is the medication being used via a non-nebulized route? ❑ **Yes** ❑ **No**

Is the medication being given in the home? ❑ **Yes** ❑ **No**

Is the medication being used in a long term care facility? ❑ **Yes** ❑ **No**

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❑ **INSULIN ADMINISTERED VIA AN INFUSION PUMP**

Diagnosis and diagnosis code: _____

Is the patient in a long term care facility? ❑ **Yes** ❑ **No**

Is the insulin administered by an insulin pump? ❑ **Yes** ❑ **No**

❑ **INTRADIALYTIC PARENTERAL NUTRITION (IDPN)/INTRAPERITONEAL NUTRITION (IPN)**

Diagnosis and diagnosis code: _____

Is the pharmacy compounding the IDPN/IPN by adding amino acids to the dialysate solution? ❑ **Yes** ❑ **No**

❑ **INTRAVENOUS IMMUNE GLOBULIN (IVIG)**

❑ Primary Immunodeficiency, diagnosis code: _____

❑ Other, specify diagnosis and diagnosis code: _____

For re-authorization requests:

Documentation of clinical improvement using objective monitoring as appropriate to the diagnosis such as, but not limited to, Rankin score and Activities of Daily Living (ADL) scores must be provided: _____

_____

❑ **ORAL ANTI-EMETIC DRUGS**

Diagnosis and diagnosis code: _____

Is the patient only receiving ORAL chemotherapy? ❑ **Yes** ❑ **No**

Has the drug been ordered by the treating practitioner as part of a cancer chemotherapy regimen? ❑ **Yes** ❑ **No**

Is the drug used as a full therapeutic replacement for an intravenous antiemetic drug that would otherwise have been administered at the time of the chemotherapy treatment? ❑ **Yes** ❑ **No**

Will this oral anti-emetic drug be initiated within two hours of the administration of the chemotherapeutic agent and continued for a period not to exceed 48 hours from that time? ❑ **Yes** ❑ **No**

❑ **ORAL CHEMOTHERAPY AGENTS**

Diagnosis and diagnosis code: _____

Does the requested medication contain the same active ingredient(s) as the non-self-administrable anti-cancer intravenous chemotherapeutic drug? ❑ **Yes** ❑ **No**

Please note: The oral anticancer drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium, or it is a prodrug which, when ingested, is metabolized into the same active ingredient which is found in the non-self-administrable form of the drug

Is the requested medication used for the same anti-cancer chemotherapeutic FDA approved indications, including "off-label" uses, as the non-self-administrable form of the drug? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by a practitioner licensed under state law to prescribe such drugs as anti-cancer chemotherapeutics? ❑ **Yes** ❑ **No**

❑ **PARENTERAL NUTRITION (TPN)**

Does the patient have a permanent dysfunction of the digestive tract? ❑ **Yes** ❑ **No**

❑ **ALL OTHER INTRAVENOUS (IV) MEDICATIONS**

Is the requested drug administered in the **home setting via an external infusion pump**? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.