HealthSun HEALTH PLANS

B VS D COVERAGE DETERMINATION FORM

This form may be sent to us by mail or fax:
Address: 11430 NW 20th St, Suite 300 Miami, FL 33172
Fax: (844) 430-1705
You may also ask us for a coverage determination by phone at (877) 336-2069

TODAY'S DATE: _____ **PHYSICIAN NAME:** _____

MEMBER NAME: _____ **PHYSICIAN PHONE:** _____

CARDHOLDER ID: HS# _____ **PHYSICIAN FAX:** _____

MEMBER DATE OF BIRTH: _____ **DIAGNOSIS:** _____

☐ **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**
BY CHECKING EXPEDITED REVIEW BOX, REQUEST WILL BE PROCESSED WITHIN 24 HOURS OF RECEIPT.

Circle name of drug being requested or indicate in "other" if not found, and check **YES** or **NO** to their corresponding question.

ORAL ANTIMETICS:		
CHLORPROMAZINE DRONABINOL GRANSETRON ONDANSETRON PROCHLORPERAZINE Other: _____ (Please indicate name of other drug)	Will oral anti-emetic be full replacement for intravenous administration within 48 hours of cancer treatment?	☐ YES ☐ NO
ORAL CHEMOTHERAPY:		
ETOPOSIDE HYCAMTIN METHOTREXATE MYLERAN RHEUMATREX SUTENT TEMODAR TREXALL VEPESID ZORTRESS Other: _____ (Please indicate name of other drug)	Is drug being used for cancer treatment?	☐ YES ☐ NO
PROPHYLACTIC VACCINES:		
COMVAX DIP/TET PED IMOVAX RABIE RABAVERT INJ TENIVAC TET/DIP TOX TETANUS TOX Other: _____ (Please indicate name of other drug)	Is the vaccines being given to TREAT an injury or direct exposure to a disease or condition?	☐ YES ☐ NO
	Will the patient get the vaccine from the pharmacy?	☐ YES ☐ NO
	Will the vaccine be administered in a physician office from a physician's supply?	☐ YES ☐ NO
HEPATITIS B VACCINE:		
ENGERIX-B RECOMBIVA-HB Other:_____ (Please indicate name of other drug)	Is the patient at High or Intermediate risk for Hepatitis?	☐ YES ☐ NO
IV IMMUNE GLOBULINS:		
ATGAM CARIMUNE NF GAMASTAN GAMMAGARD GAMMAPLEX GAMUNEX GAMUNEX-C PRIVIGEN THYMOGLOBULIN Other: _____ (Please indicate name of other drug)	Is the diagnosis primary immune deficiency disease?	☐ YES ☐ NO
	Is the drug being administered at the patient's home?	☐ YES ☐ NO
ESRD:		
ARANESP DOXERCALCIFEROL SALM/CALCITONIN 200MG/ML CALCITRIOL Other: _____ (Please indicate name of other drug)	Does the patient have Chronic Kidney Disease stage V (ESRD)?	☐ YES ☐ NO
	Is patient on dialysis?	☐ YES ☐ NO
INHALATION DRUGS:		
ACETYLCYSTEINE ALBUTEROL BUDESONIDE SOL CROMOLYN SOD IPRATROPIUM BROM IPRATROP/ALBUTEROL LEVALBUTEROL NEBUPENT PULMICORT PULMOZYME TOBI TOBRAMYCIN VENTAVIS VIRAZOLE Other: _____ (Please indicate name of other drug)	Is the drug being used in a nebulizer?	☐ YES ☐ NO
	Where will the drug be used? Check a box below ☐ Home ☐ Hospital ☐ SNF Specify _____ ☐ Nursing Home Specify _____	

PARENTERAL NUTRITION:

AMINOSYN	FREAMINE	NAGLAZYME
CLINIMIX	HEPATASOL	PREMASOL
CLINIMIX E	INTRALIPID	PROCALAMINE
CLINISOL SF	LEVOCARNITINE	PROSOL
DEXTROSE	LIPOSYN II-III	TROPHAMINE

Other: _____ (Please indicate name of other drug)

Is the therapy being provided because of a non-functioning digestive tract? ☐ YES ☐ NO

INJECTABLE/INFUSIBLE DRUGS:

ABRAXANE	ELLENCE	MUSTARGEN
ALDURAZYME	EPIRUBICIN	NAGLAZYME
ALIMTA	ERBITUX	NIPENT
AMBISOME	ETOPOSIDE	ONCASPAR
AMPHOTERICIN	FABRAZYME	OXALIPLATIN
ARRANON	FASLODEX	PACLITAXEL
ARZERRA	FIRMAGON	PENTOSTATIN
AVASTIN	FLUDARABINE	PERJETA
BELEODAQ	FLUOROURACIL	PROCAINAMIDE
BICNU	FOLOTYN	PROLASTIN
BLEOMYCIN	FOSCARNET	PROLEUKIN
BUSULFEX	FUSILEV	RITUXAN
CANCIDAS	GANCICLOVIR	SYNERCID
CAPASTAT	GEMCITABINE	TEFLARO
CARBOPLATIN	HALAVEN	TOPOSAR
CEREZYME	HERCEPTIN	TOPOTECAN
CISPLATIN	IDAMYCIN	TORISEL
CYTARABINE	IDARUBICIN	TREANDA
CLOLAR	IFOSFAMIDE	TRELSTAR
COSMEGEN	INTRON A	TRISENOX
CUBICIN	IRINOTECAN	TYGACIL
DOXORUBICIN	ISTODAX	TYSABRI
DACARBAZINE	IXEMPRA	UVADEX
DAUNORUBICIN	JEVTANA	VECTIBIX
DEPO-PROVERA	KEPIVANCE	VELCADE
DEXRAZOXANE	LEUPROLIDE	VINBLASTINE
DOCEFREZ	LEUPROLIDE ACET	VINCASAR
DOCETAXEL	LIDOCAINE	VINCRISTINE
DOXIL	MELPHALAN	VINORELBINE
DOXORUBICIN	METRONIDAZOLE 5 MG/ML	YERVOY
ELAPRASE	MITOMYCIN	ZALTRAP
ELIGARD	MITOXANTRON	ZANOSAR
ELITEK		

Other: _____ (Please indicate name of other drug)

INFUSIBLE DRUGS:

Where will the drug be infused? Check a box below

☐ Home ☐ Hospital ☐ SNF Specify _____ ☐ Nursing Home Specify _____

Is the drug being administered using the infusion pump or an implantable pump? ☐ YES ☐ NO

If medication is infused using another method, please indicate _____

INJECTABLE DRUGS:

Will the patient get the drug from the pharmacy? ☐ YES ☐ NO

Will the drug be administered in a physician's office from a physician's supply? ☐ YES ☐ NO

REVISED 11/30/2021

REQUESTOR'S NAME: _____ REQUESTOR'S SIGNATURE: _____

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

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