

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.

corresponding question.					
ORAL ANTIMETICS:					
CHLORPROMAZINE DRONABINOL	GRANSETRON F ONDANSETRON	PROCHLORPERAZINE	Will oral anti-emetic be full replacement for intravenous administration within 48 hours of cancer treatment?	☐ YES ☐ NO	
Other:	(Please i	ndicate name of other drug)			
ORAL CHEMOTHERAPY					
ETOPOSIDE	MYLERAN	TREXALL			
HYCAMTIN	RHEUMATREX	VEPESID	Is drug being used for cancer treatment?	☐ YES ☐ NO	
METHOTREXATE	SUTENT TEMODAR	ZORTRESS			
Other:		ndicate name of other drug)			
PROPHYLACTIC VACCI	NES:				
COMVAX	RABAVERT INJ	TETANUS TOX	Is the vaccines being given to TREAT an injury or		
DIP/TET PED	TENIVAC		direct exposure to a disease or condition?	☐ YES ☐ NO	
IMOVAX RABIE	TET/DIP TOX (Please i	ndicate name of other drug)	·		
Offici.	(i icase i	raicale flame of office alogy	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		la the particular at High or Intermediate risk for Headitie?	□ YES □NO	
Other:	(Please II	ndicate name of other drug)	Is the patient at High or Intermediate risk for Hepatitis?	L 153 L 100	
IV IMMUNE GLOBULINS:					
ATGAM CARIMUNE NF GAMASTAN	GAMMAGARD GAMMAPLEX GAMUNEX	GAMUNEX-C PRIVIGEN THYMOGLOBULIN	Is the diagnosis primary immune deficiency disease?	☐ YES ☐ NO	
Other:	(Please i	ndicate name of other drug)	Is the drug being administered at the patient's home?	☐ YES ☐ NO	
ESRD:					
ARANESP DOXERCALCIFEROL	SALM/CA CALCITRIO	LCITONIN 200MG/ML DL	Does the patient have Chronic Kidney Disease stage V (ESRD)?	☐ YES ☐ NO	
Other:	(Please in	dicate name of other drug)	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	Is the drug being used in a nebulizer?	☐ YES ☐ NO	
Other:	(Please ir	ndicate name of other drug)	Where will the drug be used? Check a box below Home Hospital SNF Specify Dursing Hom	e Specify	

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PARENTERAL NUTRITION:				
AMINOSYN	FREAMINE	NAGLAZYME	Is the therapy being provided because of a non-	
CLINIMIX	HEPATASOL	PREMASOL	functioning digestive tract?	☐ YES ☐ NO
CLINIMIX E	INTRALIPID	PROCALAMINE		
CLINISOL SF	LEVOCARNITINE	PROSOL		
DEXTROSE	LIPOSYN II-III	TROPHAMINE		
Other:		indicate name of other drug)		
INJECTABLE/INFUSIB	LE DRUGS:			
			INFUSIBLE DRUGS:	
ABRAXANE	ELLENCE	MUSTARGEN	Where will the drug be infused? Check a box below	
ALDURAZYME	EPIRUBICIN	NAGLAZYME	☐ Home ☐ Hospital ☐ SNF Specify ☐ Nursing Hon	ne Specify
ALIMTA	ERBITUX	NIPENT	= 1101110 = 1100pilal = 0111 opcolity ==== = 11010ility 11011	.о ороон,
AMBISOME	ETOPOSIDE	ONCASPAR		
AMPHOTERICIN	FABRAZYME	OXALIPLATIN	Is the drug being administered using the infusion	
ARRANON	FASLODEX	PACLITAXEL	pump or an implantable pump?	☐ YES ☐ NO
ARZERRA	FIRMAGON	PENTOSTATIN	pomp of an implantable pompy	
AVASTIN	FLUDARABINE	PERJETA	If medication is infused using another method, please	
BELEODAQ	FLUOROURACIL	PROCAINAMIDE	indicate	
BICNU	FOLOTYN	PROLASTIN	macaro	
BLEOMYCIN BUSULFEX	FOSCARNET FUSILEV	PROLEUKIN RITUXAN		Į.
CANCIDAS	GANCICLOVIR	SYNERCID		
CAPASTAT	GEMCITABINE	TEFLARO		
CARBOPLATIN	HALAVEN	TOPOSAR	INJECTABLE DRUGS:	
CEREZYME	HERCEPTIN	TOPOTECAN	Will the patient get the drug from the pharmacy?	
CISPLATIN	IDAMYCIN	TORISEL		☐ YES ☐ NO
CYTARABINE	IDARUBICIN	TREANDA	Will the drug be administered in a physician's office	
CLOLAR	IFOSFAMIDE	TRELSTAR	from a physician's supply?	☐ YES ☐ NO
COSMEGEN	INTRON A	TRISENOX	1 , , , , , , , , , , , , , , , , , , ,	•
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			
ELAPRASE	MITOMYCIN	ZALTRAP		
ELIGARD	MITOXANTRON	ZANOSAR		
ELITEK				
Other:	(Please i	ndicate name of other drug)		
			REVISED 3	11/30/2021

REQUESTOR'S NAME:	REQUESTOR'S SIGNATURE:	

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HSHP_2022_BVSD_ENG

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