HealthSun HEALTH PLANS

B VS D COVERAGE DETERMINATION FORM

This form may be sent to us by mail, email, or fax:

Address: 3250 Mary Street, Suite 400 Coconut Grove, FL 33133 Email: PartDServices@healthsun.com Fax: (305)643-4323

You may also ask us for a coverage determination by phone at (305) 460-3901

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 questions

ORAL ANTIEMETICS:				
CHLORPROMAZINE	GRANISETRON	PROCHLORPERAZINE	Will oral anti-emetic be full replacement for intravenous administration within 48 hours of cancer treatment?	☐Yes ☐No
DRONABINOL	ONDANSETRON	PROMETHAZINE		
Other: _____ (Please indicate name of other drug)				
ORAL CHEMOTHERAPY				
ETOPOSIDE	RHEUMATREX	VEPESID	Is drug being used for cancer treatment?	☐Yes ☐No
HYCAMTIN	SUTENT	ZORTRESS		
METHOTREXATE	TEMODAR			
MYLERAN	TREXALL			
Other: _____ (Please indicate name of other drug)				
PROPHYLACTIC VACCINES:				
COMVAX	RABAVERT INJ	TETANUS TOX	Is the vaccine being given to TREAT an injury or direct exposure to a disease or condition?	☐Yes ☐No
DIP/TET PED	TENIVAC		Will the patient get the vaccine from the pharmacy?	☐Yes ☐No
IMOVAX RABIE	TET/DIP TOX		Will the vaccine be administered in a physician's office from a physician's supply?	☐Yes ☐No
Other: _____ (Please indicate name of other drug)				
HEPATITIS B VACCINE:				
RECOMBIVAX HB	RECOMBIVA-HB		Is the patient at High or Intermediate risk for Hepatitis?	☐Yes ☐No
Other: _____ (Please indicate name of other drug)				
IV IMMUNE GLOBULINS:				
ATGAM	GAMMAGARD	GAMUNEX-C	Is the diagnosis primary immune deficiency disease?	☐Yes ☐No
CARIMUNE NF	GAMMAPLEX	PRIVIGEN	Is the drug being administered at the patient's home?	☐Yes ☐No
GAMASTAN	GAMUNEX	THYMOGLOBULIN		
Other: _____ (Please indicate name of other drug)				
ESRD:				
ARANESP	SALM/CALCITONIN 200MG/ML		Does patient have Chronic Kidney Disease stage V (ESRD)?	☐Yes ☐No
PROCRIT	CALCITRIOL		Is patient on dialysis?	☐Yes ☐No
DOXERCALCIFEROL				
Other: _____ (Please indicate name of other drug)				
IMMUNOSUPRESSANTS:				
ARCALYST	CYCLOSPORINE	RAPAMUNE	Did Medicare pay for (All or part) of the transplant?	☐Yes ☐No
ASTAGRAF XL	GENGRAF	REMICADE		
AZASAN	MYCOPHENOLATE	SANDIMUNE		
AZATHIOPRINE	MYCOPHENOLIC	SIMULECT		
BENLYSTA	MYFORTIC	TYSABRI		
CELLCEPT	NULOJIX			
CYCLOPHOSPHAMIDE	PROGRAF INJ			
Other: _____ (Please indicate name of other drug)				
INHALATION DRUGS:				
ACETYLCYSTEINE	IPRATROP/ALBUTEROL	TOBI	Is this drug being used in a nebulizer?	☐Yes ☐No
ALBUTEROL	LEVALBUTEROL	TOBRAMYCIN		
BUDESONIDE SOL	NABUPENT	VENTAVIS	Where will the drug be used? Check a box below	
CROMOLYN SOD	PULMICORT	VIRAZOLE	☐ Home ☐Hospital ☐ SNF Specify_____ ☐ Nursing Home Specify_____	
IPRATROPIUM BROM	PULMOZYME			
Other: _____ (Please indicate name of other drug)				

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	LUPRON	VINORELBINE
DOXORUBICIN	MELPHALAN	YERVOY
ELAPRASE	METRONIDAZOLE 5 MG/ML	ZALTRAP
ELIGARD	MITOMYCIN	ZANOSAR
ELITEK	MITOXANTRON	

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 an 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 7/13/2016

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). HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.

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