HealthSun HEALTH PLANS

B VS D COVERAGE DETERMINATION FORM

This form may be sent to us by mail or fax:
Address: 9250 W Flagler St, Suite 600 Miami, FL 33174
Fax: (844) 430-1705
You may also ask us for a coverage determination by phone at (877) 336-2069

TODAY'S DATE: ____________________

MEMBER NAME: ____________________

CARDHOLDER ID: HS# ____________________

MEMBER DATE OF BIRTH: ____________________

PHYSICIAN NAME: ____________________

PHYSICIAN PHONE: ____________________

PHYSICIAN FAX: ____________________

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.

Drug	Question	Answer
ORAL ANTIMETICS:		
CHLORPROMAZINE, GRANSETRON, PROCHLORPERAZINE, DRONABINOL, ONDANSETRON, ONDANSETRON 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, MYLERAN, TREXALL, HYCAMTIN, RHEUMATREX, VEPESID, METHOTREXATE, SUTENT, ZORTRESS, TEMODAR Other: __________ (Please indicate name of other drug)	Is drug being used for cancer treatment?	☐ YES ☐ NO
PROPHYLACTIC VACCINES:		
COMVAX, RABAVERT INJ, TETANUS TOX, DIP/TET PED, TENVAC, IMOVAX RABIE, TET/DIP 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:		
RECOMBIVAX HB, 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, GAMMAGARD, GAMUNEX-C, CARIMUNE NF, GAMMAPLEX, PRIVIGEN GAMASTAN, GAMASTAN, GAMUNEX, 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, SALM/CALCITONIN 200MG/ML, DOXERCALCIFEROL, 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, IPRATROP/ALBUTEROL, TOBI, ALBUTEROL, LEVALBUTEROL, TOBRAMYCIN, BUDESONIDE SOL, NABUPENT, VENTAVIS, CROMOLYN SOD, PULMICORT, VIRAZOLE, IPRATROPIUM BROM, PULMOZYME 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 CLINIMIX CLINIMIX E CLINISOL SF DEXTROSE Other: ___________________	FREAMINE HEPATASOL INTRALIPID LEVOCARNITINE LIPOSYN II-III (Please indicate name of other drug	NAGLAZYME PREMASOL PROCALAMINE PROSOL TROPHAMINE	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
BUSUFLEX	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? If medication is infused using another method, please indicate ____________________________	☐ YES ☐ NO

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

REQUESTOR'S NAME: ____________________________________ REQUESTOR'S SIGNATURE: ______________________________

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