

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: _____	PHYSICIAN NAME: _____
MEMBER NAME: _____	PHYSICIAN PHONE: _____
CARDHOLDER ID: HS# _____	PHYSICIAN FAX: _____
MEMBER DATE OF BIRTH: _____	DIAGNOSIS: _____
<input type="checkbox"/> 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 ONDANSETRON
Other: _____ (Please indicate name of other drug)		Will oral anti-emetic be full replacement for intravenous administration within 48 hours of cancer treatment? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
PROPHYLACTIC VACCINES:		
COMVAX DIP/TET PED IMOVAX RABIE	RABAVERT INJ TENVAC 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
		Will the patient get the vaccine from the pharmacy? <input type="checkbox"/> YES <input type="checkbox"/> NO
		Will the vaccine be administered in a physician office from a physician's supply? <input type="checkbox"/> YES <input type="checkbox"/> NO
HEPATITIS B VACCINE:		
RECOMBIVAX HB Other: _____	RECOMBIVA-HB (Please indicate name of other drug)	
		Is the patient at High or Intermediate risk for Hepatitis? <input type="checkbox"/> YES <input type="checkbox"/> NO
IV IMMUNE GLOBULINS:		
ATGAM CARIMUNE NF GAMASTAN	GAMMAGARD GAMMAPLEX GAMUNEX	GAMUNEX-C PRIVIGEN GAMASTAN THYMOGLOBULIN
Other: _____ (Please indicate name of other drug)		Is the diagnosis primary immune deficiency disease? <input type="checkbox"/> YES <input type="checkbox"/> NO
		Is the drug being administered at the patient's home? <input type="checkbox"/> YES <input type="checkbox"/> NO
ESRD:		
ARANESP DOXERCALCIFEROL Other: _____	SALM/CALCITONIN 200MG/ML CALCITRIOL (Please indicate name of other drug)	
		Does the patient have Chronic Kidney Disease stage V (ESRD)? <input type="checkbox"/> YES <input type="checkbox"/> NO
		Is patient on dialysis? <input type="checkbox"/> YES <input type="checkbox"/> NO
INHALATION DRUGS:		
ACETYLCYSTEINE ALBUTEROL BUDESONIDE SOL CROMOLYN SOD IPRATROPIUM BROM	IPRATROP/ALBUTEROL LEVALBUTEROL NABUPENT PULMICORT PULMOZYME	TOBI TOBRAMYCIN VENTAVIS VIRAZOLE
Other: _____ (Please indicate name of other drug)		Is the drug being used in a nebulizer? <input type="checkbox"/> YES <input type="checkbox"/> NO
		Where will the drug be used? Check a box below <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> SNF Specify ____ <input type="checkbox"/> Nursing Home Specify ____
PARENTERAL NUTRITION:		

AMINOSYN CLINIMIX CLINIMIX E CLINISOL SF DEXTROSE Other: _____	FREAMINE HEPATASOL INTRALIPID LEVOCARNITINE LIOSYN 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
INJECTABLE/INFUSIBLE DRUGS:			INFUSIBLE DRUGS:
ABRAXANE ALDURAZYME ALIMTA AMBISOME AMPHOTERICIN ARRANON ARZERRA AVASTIN BELEODAQ BICNU BLEOMYCIN BUSUFLEX CANCIDAS CAPASTAT CARBOPLATIN CEREZYME CISPLATIN CYTARABINE CLOLAR COSMEGEN CUBICIN DOXORUBICIN DACARBAZINE DAUNORUBICIN DEPO-PROVERA DEXRAZOXANE DOCEFREZ DOCETAXEL DOXIL DOXORUBICIN ELAPRASE ELIGARD ELITEK Other: _____	ELLECE EPIRUBICIN ERBITUX ETOPOSIDE FABRAZYME FASLODEX FIRMAGON FLUDARABINE FLUOROURACIL FOLOTYN FOSCARNET FUSILEV GANCICLOVIR GEMCITABINE HALAVEN HERCEPTIN IDAMYCIN IDARUBICIN IFOSFAMIDE INTRON A IRINOTECAN ISTODAX IXEMPRA JEVTANA KEPIVANCE LEUPROLIDE LEUPROLIDE ACET LIDOCAINE MELPHALAN METRONIDAZOLE 5 MG/ML MITOMYCIN MITOXANTRON (Please indicate name of other drug)	MUSTARGEN NAGLAZYME NIPENT ONCASPAR OXALIPLATIN PACLITAXEL PENTOSTATIN PERJETA PROCAINAMIDE PROLASTIN PROLEUKIN RITUXAN SYNERCID TEFLARO TOPOSAR TOPOTECAN TORISEL TREANDA TRELSTAR TRISENOX TYGACIL TYSABRI UVADEX VECTIBIX VELCADE VINBLASTINE VINCASAR VINCRISTINE VINORELBINE YERVOY ZALTRAP ZANOSAR	Where will the drug be infused? Check a box below <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> SNF Specify _____ <input type="checkbox"/> Nursing Home Specify _____
			Is the drug being administered using the infusion pump or an implantable pump? <input type="checkbox"/> YES <input type="checkbox"/> NO
			If medication is infused using another method, please indicate _____
			INJECTABLE DRUGS:
			Will the patient get the drug from the pharmacy? <input type="checkbox"/> YES <input type="checkbox"/> NO
			Will the drug be administered in a physician's office from a physician's supply? <input type="checkbox"/> YES <input type="checkbox"/> NO

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

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