

# RxOptions, Inc.

## Medicare Part D

### Prior Auth Request

**Please complete this form, scan and email to: Adriana.Medina@health-sun.com**

**Pharmacy Department: (305) 447-4448 ext. 254**

CARDHOLDER ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

BENEFICIARY NAME \_\_\_\_\_ DATE: \_\_\_\_\_

Please place a check mark in the column next to the appropriate drug name and fill in the corresponding lines. If a drug is to be covered as a Part D drug, please complete the information under the table.

SELECT DRUG	NAME OF DRUG	CRITERIA	Y / N	RESOLUTION	COVER AS PART D Y/N
	ALLEGRA/D (fenofaxadine) or CLARINEX/D (desloratadine/d)	Has patient tried and failed Claritin OTC?		If yes, then cover as part D. If no, then member must try Claritin/D OTC first.	
	ANZEMET (dolasetron)	Is oral drug replacing IV administration within 48 hours of chemo?		If yes, should be Part B.	
	ARANESP (darbepoetin alpha)	Does Beneficiary have End Stage Renal Disease?		If yes, should be Part B.	
	AVITA (tretinoin)	Is treatment for actinic keratosis or melasma?		If No, then not a covered drug.	
	CYTOXAN, (cyclophosphamide)	Is treatment for cancer?		If yes, should be Part B.	
	EMEND (aprepitant)	Is oral drug replacing IV administration within 48 hours of chemo?		If yes, should be Part B.	
	ENERGIX B (hepatitis B vaccine, recombinant)	Is Patient a low risk patient?		If no, should be Part B.	
	EPOGEN (epoetin alpha)	Does Beneficiary have End Stage Renal Disease?		If yes, should be Part B.	
	IMMUNE GLOBULI (Immune Serums)	Does Beneficiary have primary immune deficiency disease?		If yes, should be Part B.	
	IMMUNOSUPPRESSANTS (cyclosporine)	Did Medicare pay for the transplant?		If yes, should be Part B.	
	INFUSABLE DME SUPPLY DRUGS	Is this used with an infusion pump?		If yes, should be Part B.	
	KYTRIL (granisetron)	Is oral drug replacing IV administration within 48 hours of chemo?		If yes, should be Part B.	

	<b>TREXALL (methotrexate)</b>	<b>Is treatment for cancer?</b>		<b>If yes, should be Part B.</b>	
	<b>PARENTERAL NUTRITION</b>  (Dextrose, Sterile Water, Amino Acids, Lipids, Sodium Chloride, Sodium Lactate)	<b>Does Beneficiary have a non- functioning GI tract?</b>		<b>If yes, should be Part B.</b>	
	<b>SINGULAIR (montelukast)</b>	<b>Is treatment for asthma?</b>		<b>If yes, drug is covered. If no, patient must have tried and failed 2 non- sedating antihistamines</b>	
	<b>TAZORAC (tazarotene)</b>	<b>Is the diagnosis psoriasis?</b>		<b>If no, then drug not covered</b>	
	<b>TRETINOIN</b>	<b>Is treatment for actinic keratosis or melasma?</b>		<b>If No, then not a covered drug.</b>	
	<b>ZOFRAN (ondansetron)</b>	<b>Is oral drug replacing IV administration within 48 hours of chemo?</b>		<b>If yes, should be Part B.</b>	

**PHYSICIAN NAME:** \_\_\_\_\_ **PHYSICIAN PHONE:** \_\_\_\_\_

**PHYSICIAN FAX:** \_\_\_\_\_ **EFFECTIVE DATES: FROM** \_\_\_\_\_ **TO** \_\_\_\_\_

**QUANTITY:** \_\_\_\_\_ **DAYS SUPPLY** \_\_\_\_\_ **(IF MORE THAN PLAN LIMITS)**

**PREVIOUS MEDICATIONS TRIED AND FAILED:**

\_\_\_\_\_

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**FOR HEALTHSUN INTERNAL USE ONLY**

**Date received:** \_\_\_\_\_ **Date reviewed:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**FOR Rx OPTIONS, INC. INTERNAL USE ONLY**

**Date received:** \_\_\_\_\_ **Date reviewed:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Reviewer's comments and actions:** \_\_\_\_\_