Prior Authorization Form

Effective January 1, 2018

Web Portal: https://eprg.wellmed.net
Fax: 1-866-322-7276

INSTRUCTIONS: Please ensure each section below is completed and all *Required* fields are filled-in appropriately. Please include only one member per form and one service or referral per request.

For example - Separate forms are required when a member is receiving physical therapy from a home health agency and is also renting durable medical equipment (DME) from a DME company.

SECTION ONE

TYPE OF REQUEST (select one)**: STANDARD**

☐ ➢ **For prompt determination, *submit ALL STANDARD requests using the Web Portal*** https://eprg.wellmed.net.

EXPEDITED

☐ ➢ ***ONLY* submit *EXPEDITED* request when the health care provider believes that waiting for a decision under the *standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function*.**

DATES OF SERVICE:

Start date:______________________ End date:_______________ # of Visits:_______________

LOCATION OF SERVICE (select one)**:**

☐ Outpatient facility ☐ Inpatient facility ☐ Home ☐ Office ☐ Ambulatory Surgical Center (ASC)

TYPE OF SERVICE (select one)**:**

☐ Medical ☐ Medicine/Injectable (see page 2) ☐ Home Health ☐ DME Purchase ☐ DME Rental ☐ Transplant
☐ Surgical ☐ Out of Network/Out of Area ☐ Diagnostic Test ☐ Transportation

CODES:

ICD 10 Code(s)_______________________________________ CPT Code(s):_______________________________________
DME Price - Rental/Monthly:_______________________________ DME Price – Purchase:_______________________________

Additional CPT codes (if applicable):

SECTION TWO

Please attach applicable supporting documents, including but not limited to medical history, labs, x-rays and diagnostic results, physician's notes and orders, progress report, and letter of medical necessity.

Missing or insufficient documents may delay the review process

PATIENT INFORMATION:

NAME: *(Required – Please Print)*_______________________________________
DATE OF BIRTH: *(Required)*_______________________________________
MEMBER ID: *(Required)*_______________________________________

SECTION THREE

REQUESTING PROVIDER

NAME: *(Required – Please Print)*_______________________________________
NPI: *(Required)*_______________________ TIN: *(Required)* _______________________
PHONE: *(Required)*_______________________ FAX: *(Required)*_______________________*(Determination will be sent to this number)*
ADDRESS: *(Required)* _______________________________________*(Correspondence will be sent to this address)*

SERVICING PROVIDER

NAME: *(Required – Please Print)*_______________________________________
NPI: *(Required)*_______________________ TIN: *(Required)* _______________________
PHONE: *(Required)*_______________________ FAX: *(Required)*_______________________*(Determination will be sent to this number)*
ADDRESS: *(Required)* _______________________________________*(Correspondence will be sent to this address)*

SERVICING FACILITY

NAME: *(Required – Please Print)*_______________________________________
NPI: *(Required)*_______________________ TIN: *(Required)*_______________________
PHONE: *(Required)*_______________________ FAX: *(Required)*_______________________*(Determination will be sent to this number)*
ADDRESS: *(Required)* _______________________________________*(Correspondence will be sent to this address)*

This form or authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, benefits, contractual limitations, provisions, and exclusions. Review of medical information, and/or medical records can be requested. Please verify benefits and eligibility prior to rendering services.

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Medicare Part B Medication Form

INSTRUCTIONS: Please ensure each section below is completed and all *Required fields are filled-in appropriately. Please include only one member per form and one service or referral per request.

Request Type: ☐ New start ☐ Renewal
Drug Name: ☐ Eylea (J0178) ☐ Lucentis (J2778) ☐ Neulasta (J2505) ☐ Aloxi (J2469) ☐ Other_________
*Please refer to the Prior Authorization list for additional medications

*********NOTE: MAXIMUM AUTHORIZATION PERIOD IS 90 DAYS, PLEASE CALCULATE THE FOLLOWING ELEMENTS ACCORDINGLY*******

TOTAL NUMBER OF INJECTIONS REQUESTED (*Required*) **:**	**DOSE and FREQUENCY** (*Required*):
TOTAL BILLING UNITS (*Required*):	**APPOINTMENT DATE(S)** (*Required*):

For *Eylea* and *Lucentis*, please submit the following additional information:

ICD 10 diagnostic code(s) (*Required*):____

☐ Neovascular (Wet) Age-Related Macular Edema ☐ Macular Edema following Retinal Vein Occlusion
☐ Diabetic macular edema ☐ Diabetic Retinopathy with Macular Edema ☐ Diabetic Retinopathy without Macular Edema
☐ Left Eye_________ ☐ Right Eye____________ ☐ Both Eyes____________

1. Has patient tried and failed treatment with Avastin® (bevacizumab) in the past?
   ☐ Yes, please provide date and reason for failure: ______________________________
   ☐ No (go to question 2)
2. Would you consider use of Avastin® (bevacizumab) for this diagnosis?
   ☐ Yes (*May proceed with treatment. Prior Authorization is NOT required for Avastin*)
   ☐ No, please provide reason:______________________________

For *Aloxi*, please submit the following additional information:

ICD-10 diagnosis code(s) (*Required*):____

☐ ***Chemotherapy induced nausea and vomiting:***	☐ ***For post-operative nausea and vomiting:***
Chemotherapy regimen(include dose and frequency of administration) ____________________________ Will patient receive Aloxi on the same day as chemotherapy? ☐ Yes ☐ No Can patient take oral medications? ☐ Yes ☐ No Has patient had intolerance, treatment failure, or contraindication to IV ondansetron OR IV granisetron at the FDA recommended doses? ☐ Yes, provide name and dose of medication tried/failed: ___________________ ☐ No	Date and Type of Surgery ____________________________ ____________________________ Can patient take oral medications? ☐ Yes ☐ No Has patient had intolerance, treatment failure, or contraindication to IV ondansetron, IV granisetron, or IV dolasetron at the FDA recommended doses? ☐ Yes, provide name and dose of the two medications tried/failed: ____________________________ ____________________________ ☐ No

For *Neulasta*, please submit the following additional information:

ICD-10 diagnosis code(s) (*Required*): ______________________________
☐ Prevention of chemotherapy-induced neutropenia
☐ Hematopoietic radiation injury syndrome
Chemotherapy regimen (include dose and frequency of administration)
____
____
Total number of cycles: _______________Last cycle date:____________________
Number of cycles remaining:______________________________
Most recent ANC date and value: ______________________________
Has patient had intolerance, treatment failure, or contraindication to other GSFs such as Neupogen, Granix or Zarxio?
☐ Yes, provide name and dose of medication tried:_________________________
☐ No

Place of administration: ☐ Home ☐ Physician's office ☐ Other: ________

Does patient meet one or more of the following risk factors (check all that apply):

☐ Age 65 or older receiving full chemotherapy dose intensity
☐ Poor performance status
☐ Prior chemotherapy or radiation therapy
☐ Persistent neutropenia
☐ Cytopenias due to marrow involvement
☐ Open wounds and/or recent surgery
☐ Advanced cancer or other comorbidities such as renal dysfunction (creatinine clearance <50), Liver dysfunction (bilirubin >2)

This form or authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, benefits, contractual limitations, provisions, and exclusions. Review of medical information, and/or medical records can be requested. Please verify benefits and eligibility prior to rendering services.