



SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Part B Prior Authorization Guidelines

Drugs / Biologics Not Otherwise Classified C9399, J3490, J3590

Prior Authorization Request Medicare Part B Form

Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.

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	NEW STA	ART - Start Date	:			uation (within 3 last treatment	•	,		
	Date Req	uested								
	Requesto	r	Clinic name:			Phone		/ Fax		
	MEMBER INFORMATION									
*Naı	*Name: *ID#: *DOB:									
			PRESCRIB							
*Naı	*Name:									
*Add	*Address: *Fax:									
DISPENSING PROVIDER / ADMINISTRATION INFORMATION										
*Name: Phone:										
*Add	*Address:									
PROCEDURE / PRODUCT INFORMATION										
нс	PC Code	Name of Drug	☐ Self-administered	Dos	e (Wt:	kg Ht:)	Frequency	End Date if known	
						_				
□С	□Chart notes attached. Other important information:									
Diagnosis: ICD10: Description:										
□ Provider attests the diagnosis provided is an FDA-Approved indication for this drug										
CLINICAL INFORMATION										
 □ New Start or Initial Request: (Clinical documentation required for all requests) □ Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria. If not, please provide clinical rationale for formulary exception: 										
 □ Continuation Requests: (Clinical documentation required for all requests) □ Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria. □ Patient had an adequate response or significant improvement while on this medication. If not, please provide clinical rationale for continuing this medication: 										
	ACKNOWLEDGEMENT									
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by pro	Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF									



Prior Authorization Group - Drugs / Biologics Not Otherwise Classified PA

Drug Name(s):

UNCLASSIFIED DRUGS / BIOLOGIC

Criteria for approval of Prior Authorization Drug:

- 1. Prescribed for an approved FDA diagnosis (as listed below):
- 2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

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N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approvals will be for 6 months NO PA REQUIRED FOR J3490

FDA Indications:

As per FDA approved resources

Off-Label Uses:

N/A

Age Restrictions:

N/A

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/73C39F/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/2DBB22/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/pf.HomePage?navitem=topHome&isToolPage=true