

Medicare Part B vs. Medicare Part D Request Form

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login **OR** covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: <u>888-446-8535</u>

Mail: Blue Cross NC, ATTN: Part D Coverage Determination

P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

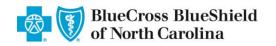
			y Delay Processing		
	er Informatio		Patient Information		
Physician Name: NPI #:		#:	Patient Name:		
Office Contact Person:			Patient ID #:		
Office Phone #: Office Fax #:			Home Phone #:		
Address:			Sex: □ Female □ Male		
City:	State: Zi	ip:	DOB:		
	Dia	anosis and Medic	cation Information		
Medication Requested:	Dia	gnosis and medic	Diagnosis Code:		
Strength and Route of Admi	inistration:				
		Please answer qı	uestions below		
Certain medications may be			or Medicare Part D and therefore, require price	or review	to
			erage database https://www.cms.gov/medica		
database/ or DMF-MAC Jui	risdiction C httr)://www.casmedicar	re.com/jc/coverage/lcdinfo.html for Part B dru	id covera	ge_
clarification).	iodiolion o <u>ma</u>	www.ogomourour	one of the second of the secon	ig covera	90
1. Is this request for an expe	edited review?.			🗆 Yes	□ No
			nrollee or his/her physician or other prescribe		
believes that waiting for	a decision und	er the standard time	frame may place the enrollee's life, health, or		
		e <mark>rious jeopardy.</mark> A sta	andard review will have a decision made within 7	2	
hours for a coverage deter	rmination.				
2. Please indicate if the requ					
☐ brand-name product	i ⊔ generi	c product			
2 Will the requested media	ation ha admin	istored by a booltha	are professional and hilled under the Bart P		
(modical) hopofit (includi	alion be admini	stered by a nealthca יייוי	are professional and billed under the Part B	□ Voc	
			nistered by the patient OR billed under the	🗀 165	
				П Vec	□Мо
i If NO n	acy) benent:	explanation of how t	the requested medication will be billed and	🗀 163	
	stered to the pa		the requested medication will be blied and		
damini	stored to the pe	MOTIC			
4. Is the requested medicati	on an oral anti	-emetic being presc	ribed for nausea and/or vomiting		
related to any of the follow					
				□ Yes	□ No
		uestion 5 on next p			
				□ Yes	□ No
D. Other				□ Yes	□ No
i. If YES, plea	ase specify co	ndition:		_	
	F	PLEASE CONTINUI	E TO NEXT PAGE		

Updated: 04/01/2025



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	For oral anti-emetics prescribed for chemotherapy-induced nausea/vomiting, please answer the following	g				
questions: A. Is the patient receiving oral chemotherapy ? i. If YES , please answer the following questions:						
	a. List the names of all oral chemotherapeutic medications the patient will receive:					
	b. Is it likely that the anti-cancer medication will cause vomiting if the requested oral anti-emetic is not given?	.□ Yes	□ No			
	c. Will the patient receive the oral anti-emetic within 2 hours before the oral anti-cancer medication is given?	ſ				
	If YES, will the patient take the oral anti-emetic after the oral anti-cancer medication is given?					
	B. Is the patient receiving IV chemotherapy?					
 i. If YES, please answer the following questions: a. Will the patient receive the oral anti-emetic within 2 hours of chemotherapy 						
	administration?	. □ Yes	□ No			
	If YES, will the patient take the oral anti-emetic beyond 48 hours of receiving chemotherapy?	. □ Yes	□ No			
	b. Will the oral anti-emetic be used as a full therapeutic replacement for IV anti-emetic medications as part of an IV cancer chemotherapeutic regimen (i.e., patient is not					
	receiving an IV anti-emetic)?	. □ Yes	□ No			
	c. Will the oral anti-emetic be used with other oral anti-emetic medications?	. □ Yes				
	medications the patient will receive:	-				
6.	Is the requested medication used in a nebulizer?	. □ Yes	□ No			
	A. If YES, please answer the following questions:					
	i. Does the patient have a diagnosis of COPD or asthma?					
	ii. Is the patient currently in a Skilled Nursing Facility or hospital?	.□ Yes .□ Yes	□ No			
7.	Is the requested medication an immunosuppressant related to organ/bone marrow transplant?	.□ Yes	□ No			
	i. Please indicate the type of transplant:					
	ii. Please provide the date of the transplant:/ iii. Did the member have Medicare Part A at the time of transplant?	. □ Yes	□ No			
8.	Is the requested medication insulin?	. □ Yes	□ No			
	i. Is the insulin used in an insulin pump?	. □ Yes	□ No			
	a. If YES , is it a disposable insulin pump (such as Omnipod or V-go)?	. □ Yes	□ No			
9. '	Will the requested medication be used in an external infusion pump (e.g., antifungal, antiviral, chemotherapy, narcotic pain medications, etc.)?	ΠVas	П Мо			
	A. If YES, will the medication be administered in the home?					
10	. Is the requested medication related to End Stage Renal Disease (ESRD)?					
	A. If YES, is the patient currently receiving dialysis?	. □ Yes	□ No			
PLEASE CONTINUE TO NEXT PAGE						



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11.	Is the requested medication a vaccination for Hepatitis B (such as Engerix-B or Recombivax)?	□ Yes □ Yes					
12. I	Is the requested medication a vaccination for Tetanus (such as Tenivac or TDVAX)?						
	Please list the names of all medications (including insulins) previously tried and failed or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to this request:	- -					
14. /	Additional information we should consider (attach any supporting documents):	-					
I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.							
Phys	sician Signature: Date:						