



Medicare Part D
Part B vs. Part D Determination
Please Fax to: (866) 855-2676

Date of Request: _____

Does Patient have Medicare Part B coverage? Yes No

Pharmacy Name _____ Pharmacy NABP # : _____

Pharmacy Phone #: _____ Pharmacy Fax # : _____

Physician's Name: _____ Physician's DEA#: _____

Phone # : _____ Fax # : _____

Patient's Name: _____ DOB: _____ Gender: _____

Patient's ID# : _____ Patient's Diagnosis : _____

Medication Needed: _____ Strength: _____

Quantity: _____ Directions: _____ Duration: _____

Is the prescription for an anti-rejection drug? Yes No

Is the prescription for immunosuppression but not for organ rejection? Yes No

Does the patient have recent history (last 30 days) of chemotherapeutic agents or HIV drugs? Yes No

Is the prescription being used for End Stage Renal Disease? Yes No

Has the patient been diagnosed with primary immune deficiency disease? Yes No

Will the medication be administered in the home? Yes No

Will the medication be used as a full therapeutic replacement for an IV anti-emetic as part of a cancer chemotherapy regimen? Yes No

Does the patient have a functioning GI tract? Yes No

Is the patient at high or moderate risk of contracting Hepatitis B? Yes No

Will the medication be infused via pump? Yes No

Will the medication be self-administered? Yes No

*** Only one medication request per form***

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.