Prescriber Criteria Form Infusion 2024 PA Fax BD-20 v2 010124.docx Infusion Pump Drugs Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Infusion Pump Drugs.

Drug Name:

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being administered via an infusion pump (excluding disposable pump)? [Note: If using a disposable pump, answer is NO since drugs via a disposable pump are covered under Part D.] [If no, then no further questions.]	Yes	No
2	Is the requested drug being administered via an infusion pump in the home (e.g., PATIENT'S HOME, NOT A FACILITY)? [If yes, then skip to question 6.]	Yes	No
3	[The answer to the following question is NO if the patient resides in his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).] Does the patient reside in one of the following skilled nursing facilities (SNF)/skilled care facilities: A) A nursing home that is dually-certified as both a Medicare skilled nursing facility and a Medicaid nursing facility (NF), B) A Medicaid-only NF that primarily furnishes skilled care, C) A non-participating nursing home (i.e., neither Medicare nor Medicaid) that provides primarily skilled care, D) An institution which has a distinct part SNF and which also primarily furnishes skilled care? [If no, then skip to question 5.]	Yes	No

4	Is Medicare Part A paying for the facility bed during the days this treatment is being requested? [No further questions.] [Note: If the answer to this question is yes, then deny and do not process through Part D.]	Yes	No
5	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished “incident to a practitioner’s service”)? [No further questions.]	Yes	No
6	Is the requested drug a narcotic analgesic for a non-cancer diagnosis?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____