Kohl's Rx

DME Requirements

Mobility Care

Kohll's Rx

Canes and Crutches

- The patient completely cannot perform an activity of daily living, is at risk for harm without assistance, or cannot complete the activity in a timely manner
  - Ex. The patient is unable to stand in order to dress or mobilize to the restroom
- The patient can safely use the cane/crutch
- The patient can benefit from using the cane/crutch

Exceptions

- Underarm, articulating, spring assisted crutches are not covered because they are deemed not reasonable and necessary (medical necessity has not been established)
- White cane for blind people is considered a “self-help” item and therefore not covered

Walkers

- The patient cannot perform an activity of daily living, is at risk for harm without assistance, or cannot complete the activity in a timely manner
- The patient is able to safely use a walker AND prove that the walker will improve movement
- Walker Type-specific requirements
    - **Heavy Duty** --- Patient >300 lbs
    - **U-Step Walker** -- severe neurologic disorder or other condition allowing the use of only one hand (e.g. Parkinson's or stroke)
    - **Walker with Enclosed Frame** ---- Will be denied
    - **Walker with Trunk Support** ---- Justification for medical necessity
    - **Leg Extensions** ---- The patient is 6 feet or taller
- ** **Notify the patient that there will be some out-of-pocket cost for a 4-wheeled walker; Medicare covers some, but not all expenses**
- ***Prescription needs to be specific about the type of walker desired. E.g. "walker misc." DOES NOT equate to "4-wheeled walker"

Chart Note Example: **"John Doe can safely use and will benefit from a walker b/c he can't walk unless he has a walker. Wheels are required for the walker because John Doe's upper body strength is not strong enough to lift the walker with each step, but he is able to push the walker."**

Manual Wheelchairs - Criteria

DOCUMENT in the patient's chart and send to Kohll's with Rx

Criteria for Coverage – Criteria A-E, and either F or G, are met

- Criteria A – mobility limitation for MRADL
- Criteria B – limitation cannot be resolved via cane or walker
- Criteria C – adequate access in-home between rooms, maneuvering space, and surfaces for use of a manual wheelchair
- Criteria D – will improve the patient's ability to perform MRADLs
- Criteria E – the patient is willing to use a wheelchair
- Criteria F – the patient has good enough upper body function and physical/mental capacities to use the wheelchair
- Criteria G – the patient has a caregiver who is able and willing to provide assistance

Manual Wheelchairs - Wheelchair Specific Criteria

- **Standard Hemi-Wheelchair** – the patient has short stature or need to place feet on the group for movement
- **Lightweight wheelchair** – the patient cannot self-propel in a standard wheelchair BUT can propel in a lightweight
- **High Strength Lightweight Wheelchair** – the patient engages in frequent activities that cannot be done in the above wheelchairs
    - AND/OR requires seat width/depth/height that cannot be accommodated in the above wheelchairs and spends 2+ hours per day in a wheelchair
- **Ultra-Lightweight Wheelchair** – the patient is a full-time MWC user
    - OR the patient has individualized axel configuration, wheel camber, seat/back angles
    - AND document medical necessity through special evaluation
    - Document the patient's routine activities AND that the patient is fully independent in the use of a wheelchair
- **Heavy-Duty Wheelchair** – Patient >250 lbs OR has severe spasticity
- **Extra Heavy-Duty Wheelchair** - >300 pounds
- **Custom MWC Base**
    - Details on why the patient requires a custom MWC and why an off-the-shelf MWC won't work
    - Describe what customizations are needed, how they will be done, and what makes the custom MWC unique
- **Wheelchair with Tilt in Space**
    - Specialty evaluation documenting medical necessity

Wheelchair Accessories

- **Adjustable arm height** -the patient requires arm height different than unadjustable arms and is in a wheelchair for more than 2 hours per day
- **Arm trough** - quadriplegic, hemiplegic, or uncontrolled arm movements
- **Elevating leg rests** - a condition or cast/brace preventing 90-degree flexion of the knee
    - Or significant edema in the lower leg or qualifies for reclining back
- **Nonstandard seat frame dimensions –** need to justify the patient's physical dimensions to determine medical necessity
- **Gear reduction drive wheel** - the patient has been self-propelling in MWC for one or more years and has had specialty evaluation
- **Non-sealed battery** - will not be covered by insurance
- **Single-mode battery charger** - powered vehicle needs a sealed lead acid battery
- **Power tilt/reclining system** – the patient meets power wheelchair coverage criteria
    - High risk for developing a pressure ulcer and cannot perform weight shift OR uses intermittent catheterization
    - OR power seating is needed to manage tone or spasticity
- **Anti rollback device –** needed for ramps
- **Safety belt –** the patient has documented weak upper body strength of stability and is unable to maintain an upright position
- **Manual fully reclining back** - the patient is a high risk for pressure ulcers and cannot shift weight or has intermittent catheterization and cannot transfer to a bed

Wheelchair Seating/Cushions

The prescriber must DOCUMENT in the patient chart and attach to prescription

- **Captain's Chair –** Covered by insurance for powered wheelchairs also covered under Medicare
- **Skin protection seat cushion** - The patient has a covered manual or power wheelchair
  - The patient has either current pressure ulcer or history of pressure ulcers OR
  - Has limited sensation in the area of contact with the seat
- **Positioning seat cushion** - The patient has significant postural asymmetries that are documented using a diagnosis code
- **Headrest -** The patient has a covered, tilting wheelchair
- **Custom fabricated seat cushion** - Meets criteria for prefabricated skin protection seat cushion and has a comprehensive evaluation from a licensed medical professional
- **Custom fabricated back cushion** - Meets criteria for prefabricated positioning back cushion and has a comprehensive evaluation

Power Scooters (POV) and Power Wheelchairs General Criteria

- A - Mobility limitation that impairs the ability to perform MRADLs
- B - Mobility limitation cannot be resolved by a fitted cane or walker
- C - The patient isn’t strong enough to self-propel in a manual wheelchair
- D - The patient can safely transfer to and from a POV, operate the steering mechanism, and maintain a stable posture/position while operating
- E - The patient is mentally and physically capable to use the POV safely
- F - The patient's home is adequately spaced and surfaced for safe use of a POV
- G - The patient weighs less than or equal to the weight capacity of the vehicle provided
- H - Use of a POV will significantly improve mobility
- I - The patient is willing to use a POV

Power Scooters (POV) and Power Wheelchairs

- **POV is covered if**
  - Meets all of the criteria listed above
- **Power Wheelchair**
  - Meets criteria A-C and G-I, but not D-F
    - AND The patient has mental/physical capacities to operate OR has a caregiver who can operate the power wheelchair but not a manual wheelchair
  - **Group 1 and Group 2 No power option - meets above criteria for a power wheelchair**
  - **Group 2 Single and Multiple Power Option - specialty assessment is needed by LCMP in a face-to-face evaluation**
    - Meets Power Wheelchair Criteria: A-C and G-I, but not D-F
    - Single Power – the patient requires a drive control interface other than the standard OR meets coverage criteria for a power tilt/power recline system
    - Multiple power
      - Uses a wheelchair mounted ventilator AND has a specialty evaluation AND wheelchair is provided by a certified supplier
  - **Group 3 Single and Multiple Power Options - the patient is immobile from a neurological condition, myopathy, or skeletal deformity**

Home and Personal Care

Kohll's Rx

Commodes

- Requirements
  - The patient is room-confined or unable to mobilize to toilet facilities
  - The patient is confined to a floor or house without toilet facilities
  - Insurance only covers commode chairs, NOT commodes placed over a toilet
  - Document medical necessity
- Heavy-duty commodes: Patient > 300 pounds

Detachable arms: requires frequent transfers or if the patient requires extra width > 23 inches

Chart Note Example: **“John Doe requires a commode next to his bed because his degenerative joint disease causes him to not be able to make it to the toilet facilities.**

Hospital Beds

- Semi-electric/Full electric hospital bed
  - **The patient requires an elevated head of 30 degrees or more due to chronic pulmonary disease, problems with aspiration, or congestive heart failure AND**
  - One of the following
    - Medical condition or Pain requires specific body positioning
    - Requires traction equipment that can only be attached to a hospital bed
  - Requires frequent changes in body position and/or has an immediate need for a change in position
- Heavy Duty Extra Wide Hospital Beds
  - The patient greater than 350 pounds, but no more than 600 pounds
- Extra Heavy Duty
  - Greater than 600 pounds

Chart Note Example: **"John Doe needs a hospital bed because his degenerative joint disease causes him to not be able to move in specific body positions to alleviate pain and needs to change positions regularly to avoid a pressure sore. Additionally, John Doe needs a bed to elevate head more than 30 degrees because of potential problems with aspiration."**

Support Surfaces for Beds: Group 1

- **Mattresses, Pressure Pads, Overlays**
  - The patient is completely immobile OR has limited mobility **WITH** one or more of:
    - Impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory
  - OR the patient has any stage pressure ulcer on the trunk or pelvis WITH any of the above conditions
  - **Required documentation of a care plan including:**
    - Education on preventing/managing ulcers
    - Regular assessment from an HCP
    - Appropriate positioning and wound care
    - Management of moisture/incontinence
    - Nutritional assessment

Support Surfaces for Beds: Group 2

- **Powered pressure reducing air mattresses, powered air flotation beds**
  - Criteria 1
    - Multiple stage 2 pressure ulcers on trunk/pelvis for 1 month AND 30 days or more of using a Group 1 support surface with a proper care plan
  - Criteria 2
    - Multiple stage 3 or 4 pressure ulcers on trunk/pelvis
  - Criteria 3
    - Within the past 60 days, myocutaneous flap or skin graft for a pressure ulcer
    - Has been on group 2 or group 3 support surface immediately prior to a recent discharge within 60 days of surgery

Support Surfaces for Beds: Group 3

- **Air Fluidized Bed**
  - Stage 3 or 4 pressure ulcers AND bedridden/chairbound because of limited mobility AND would require institutionalization without a Group 3 support bed
  - The physician evaluates and assesses the patient within 1 month prior to ordering the bed to optimize all other options
  - The patient is treated for at least 1-month using
    - Frequent repositioning every 2 hours AND using Group 2 surface AND resolving wound infections and nutritional status
    - Debriding of the wound bed, maintaining moist and clean granulation tissue
  - **Continued coverage**
    - **Documented on the chart every month with a written statement**
      - **Size of ulcer, healing status of ulcer, AND continued use of bed is medically necessary**

Support Surfaces Chart Note Example: **"John Doe has incontinence and has limited mobility, so he requires a Group 1 pressure-relieving mattress."**

Patient Lifts

- Transfer between bed and a chair/wheelchair/commode is required AND the patient is bed-confined otherwise
- Transfer to a wheelchair or commode requires the assistance of more than one person
- If a multi-positional lift is required, document the patient’s needs to be in a supine position for transfers

Seat Lift Chairs

- The patient must be able to safely move once standing
- Specific diagnosis of severe arthritis of hip/knee or severe neuromuscular disease
- Must be part of a treatment plan to improve patient function or slow deterioration
- The patient must be incapable of standing from any chair currently at home

Special Considerations:

- **Diagnoses other than severe arthritis of hip/knee or severe neuromuscular disease will not qualify the patient for a lift chair**
- **If the patient is in a wheelchair and/or insurance has paid for a wheelchair in the past, a lift chair is generally not covered.**
- **Insurance (except Welfare) only pays for the motorized lifting mechanism in a lift chair. They don't pay for the furniture portion of the lift chair.**

Chart Note Example: **"John Doe has severe arthritis in his hip, so he needs a lift chair because he is not able to stand up from any chair in his home. He is able to walk with the aid of a walker."**

Orthopedic Footwear

- **If an integral part of a covered leg brace – shoes, heel replacements, soles, shoe transfers, and inserts are covered if deemed medically necessary**
- **Exceptions – will be denied**
  - Shoes billed separately from a brace or put over a lower extremity prosthesis
  - Foot pressure supportive device

Diabetic Shoes

- Documented diabetes mellitus
- The patient's history or foot exam indicates one of the following conditions defined
  - Previous amputation of the other foot or part of either foot
  - History of previous foot ulceration
  - History of pre-ulcerative callus
    - If there is previous history, it must be documented on the current chart
  - Foot deformity of either foot
  - Poor circulation in either foot
- The patient is being treated under "a comprehensive plan of care for diabetes" by the prescribing physician
- The patient needs 1 pair of special shoes AND 3 PAIRS OF INSERTS because of diabetes (inserts should be in prescription as well)

Note: Shoes must be dispensed within 6 months of the prescription order and feet must be evaluated within 6 months of receiving the shoes

Chart Note Example: **"John Doe has type II Diabetes. He is under a comprehensive plan of care for his diabetes. I examined his feet today and determined he needs diabetes shoes and inserts. It is noted that he has poor circulation in his left foot."**

Ostomy Supplies

- The patient has a stoma
  - Document location, construction, AND condition of the skin around the stoma
- Quantity above Normal Monthly Allowances
  - Document medical necessity for the quantity required on the patient's chart
  - In a nursing home, limited to a 1-month supply
  - If the beneficiary is at home, limited to a 3-month supply

Example: **"John Doe has an end stoma on the right lower quadrant. The skin around the stoma is intact."**

Urological Supplies

- **Urinary catheters and external urinary collection devices**
  - Permanent urinary incontinence/retention not to be resolved within 3 months
- **Indwelling catheters**
  - No more than 1 catheter change per month
  - Document reason if changing more often
- **Specialty indwelling catheter or silicone catheter**
  - Meets criteria for indwelling catheter AND
    - Recurring encrusting, inability to pass a straight catheter, or latex sensitivity
- **3-way indwelling catheter +/- other components**
  - History of obstruction of catheter AND catheter cannot be maintained by intermittent irrigation with catheter changes
- **Non-routine changes in the urinary drainage collection system**
  - Medically necessary due to:
    - Obstruction, sludging, blood clots, chronic UTIs
- **Leg Bags** - the patient is ambulatory or chair or wheelchair-bound

Urological Supplies

- **Intermittent irrigation of Indwelling Catheters**
  - Presence of acute obstruction in the catheter
- **Continuous Irrigation of Indwelling Catheters**
  - History of obstruction, cannot be maintained with intermittent irrigation and catheter changes
  - AND medical necessity WITH rate of solution administration/how long they need it
- **Intermittent Catheterization** - Basic coverage met AND the patient/caregiver is able to perform catheterization
- **Sterile Intermittent Catheterization** - Meets intermittent catheterization criteria
  - The patient is in a nursing facility, immunosuppressed, documented vesicoureteral reflux, OR has distinct, recurrent UTI twice in a 12 month period
  - OR the patient is pregnant with spinal-cord injury and neurogenic bladder
- **Curved Tip Catheter** - Document for medical necessity
- **External Catheter/urinary collection devices** - Shown to be medically necessary as an alternative to an indwelling catheter for permanent urinary incontinence

Chart Note Example: **“John Doe needs urinary catheters for urinary incontinence that has lasted 6 months without resolution.”**

Orthoses and Prostheses

Kohll's Rx

Ankle-foot Braces

- Ankle-foot braces for ambulation, need ALL of:
  - Is ambulatory
  - Has a weakness/deformity of the foot and ankle
  - Requires stabilization of foot and ankle for “medical reasons”
  - Has the potential to benefit functionally from the use of an ankle-foot brace
- Ankle-foot braces NOT for ambulation, one of the following:
  - Plantar fasciitis
  - Plantar flexion contracture of the ankle with dorsiflexion with ALL of the following
    - Passive range of motion testing of at least 10 degrees with a goniometer
    - Expect contracture to be corrected
    - Contracture is interfering or expected to interfere significantly with the beneficiary’s functional abilities
    - The ankle-foot brace is used as a component of a “comprehensive therapy program”

Knee-ankle-foot, Other Braces

- Knee-ankle-foot braces: Ankle-foot braces PLUS need for additional knee stability
- Custom-fitted braces: In addition to the basic criteria, any one of the following supported by the orthotist/prosthetist's record:
  - The prefabricated brace will not fit the patient
  - Condition necessitating the orthosis is expected to be more than 6 months
  - Need to control knee, ankle, or foot in more than one plane
  - A neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury
  - Healing fracture has abnormal proportions or anatomy
- For concentric adjustable torsion style mechanisms, ONE of the following criteria must be met:
  - Needed to assist knee joint extension, ankle joint plantar flexion, or dorsiflexion in ABSENCE OF CO-EXISTING JOINT CONTRACTURE
  - Needed to treat contractures REGARDLESS OF CO-EXISTING JOINT CONTRACTURE(S)

External Breast Prostheses

- Documented that the patient has had a mastectomy and has not had any reconstructive surgery
- A prescription must specify **both prosthetics and bras**
- Office visit documenting need within the last year
- Quantity allowed

Knee Orthoses

- **Prescription MUST SPECIFY material in orthosis requested (metal or plastic), whether the orthosis is used to IMMOBILIZE or SUPPORT the knee joint**
- **Prefabricated knee orthoses**
  - The prescriber must document the extent of knee movement and weakness
  - The patient is ambulatory
  - Documentation of examination for knee instability
  - Document etiology or source of knee instability (i.e. surgery or injury)
- **Custom Fabricated Knee Orthoses**
  - The patient has a deformity of knee/leg OR documented size of thigh/calf OR insufficient muscle to support orthosis
  - Custom orthoses need to meet all criteria for prefabricating orthoses

Spinal Orthoses: TLSO and LSO

- **Prefabricated Orthoses off the shelf** - Indicated for any of the following:
  - Reduce pain by restricting trunk movement
  - Facilitate healing following injury or surgery of spine/related soft tissue
  - Support weak spinal muscles/deformed spine
- **Prefabricated Orthoses: Custom fitted**
  - Indicated for any of the above AND
  - Requires more than minimal self-adjustment for fitting AND
  - Fitting requires the expertise of a certified orthotist or specialist
  - Document detailed description of necessary modifications
- **Custom Fabricated Orthoses**
  - Indicated for any of the above
  - Documentation for medical necessity of fabricating a custom orthosis, supported with a functional evaluation on record
  - An imprint of the body part was made to model the fabrication, detailed measurements were taken, or a digital image was made
  - The custom orthosis was made and molded

Wound Care

Kohll's Rx

Negative Pressure Wound Therapy Pumps

- **Must document a history of previous treatments and wound evaluation**
  - Length of sessions, dressing type, how often dressing changed, changes in wound conditions
  - Regular evaluation of wound
  - Month-by-month comparisons of wound

Negative Pressure Wound Therapy Pumps: Initial Coverage

One of the following two wound criteria met

- **Ulcers and wounds in-home setting**
  - Stage 3 or 4 ulcer or a chronic ulcer of mixed origin for 30 days
  - Document full wound therapy program AND one of the following:
    - Stage 3 or 4 pressure ulcers
      - The patient has been turned and positioned properly and used a group 2 or 3 support surface
      - Moisture and incontinence are managed
    - Neuropathic ulcers
      - The patient is on a “comprehensive diabetic management” program and pressure has been reduced on a foot ulcer properly
    - Venous insufficiency ulcers
      - Consistent use of compression bandages
      - Documented leg elevation and ambulation
- **Inpatient ulcers and wounds**
  - Treatments for outpatient ulcers have been tried/considered/ruled out
  - NWPT is the best available option OR the patient has complications on a surgery or trauma wound that requires NWPT

Negative Pressure Wound Therapy Pumps: Exclusions and Continued Coverage

- **Exclusion criteria** - Insurance will not cover:
  - Necrotic tissue without debridement
  - Untreated osteomyelitis
  - Cancer in the wound
  - Open fistula

Continued coverage

- Monthly documentation of changes in ulcer's size and description
- Regular assessment and changing of dressings
- **Coverage will end if**
  - The wound is sufficiently healed per MD or wound healing has failed in the past month
  - 4 months have passed unless deemed medically necessary with more documentation

Surgical Dressings

- **Basic coverage criteria**
  - Used for a wound from surgery or debridement of a wound
  - Define type, depth, location, size, and number of wounds and whether using a primary or secondary dressing
  - Re-evaluate wound every month unless justified otherwise (more frequent in LTC)

Additional dressing specific criteria

- **Alginates** - exudative full-thickness wounds (e.g. Stage 3 or 4 ulcers), NOT dry wounds
  - Change dressings once per day
- **Foam Dressings** - full-thickness wounds with heavy exudate, changed 3 times per week
  - Change wound fillers once per day
- **Collagen Dressings** - for full-thickness wounds with light exudate or dry wounds that have not reached healing goal

Chart Note Example: **“John Doe needs a surgical dressing for a stage 3 diabetic foot ulcer after surgical debridement.”**

Surgical Dressings: Wound Characteristics

- Type of wound: E11.621 (type 2 diabetes mellitus with foot ulcer)
- Location: the heel of the left foot
- Length: 25 mm
- Width: 20 mm
- Depth: 2 mm
- Amount of drainage: slight

Product required: Hydrocolloid dressing, 4”x4.75”

- Frequency of use: up to 3 times per week

Transcutaneous Electrical Nerve Stimulators (TENS)

PRESCRIBER ORDERING MUST BE TREATING PHYSICIAN IN DISEASE

- Acute Postoperative Pain
  - No more than 30 days from the day of surgery, only as a rental
  - Date, nature of surgery and location/severity of pain
- Chronic Pain **OTHER than Lower Back Pain** - trial from between 30 days to 2 months, paid as a rental
  - Source of pain accepted as responding to TENS and present for at least 3 months
  - document previous treatments and results
  - Location, severity, duration, etiology of pain
  - Reevaluation of how often, duration, and results of TENS use
  - Determine and document that patient will likely have significant benefit for long periods of time
  - If writing for 4 leads, document why 2 leads is not enough

Transcutaneous Electrical Nerve Stimulators (TENS)

- Chronic Lower Back Pain
  - Diagnosis in Diagnosis Codes that Support Medical Necessity Section of LCD and **enrolled in an approved clinical study**
  - If writing for 4 leads, document why 2 leads is not enough
- Conductive Garment – only covered if
  - Too large of a site or too many sites to be stimulated AND stimulation would be so frequent that it isn't feasible with electrodes
  - OR sites are inaccessible
  - OR medical condition on skin that precludes applying electrodes
  - Only covered if documented skin problem is present before starting the trial
- **If low back pain is the only diagnosis, TENS will not be covered**

Chart Note Example: **"John Doe has had chronic, intractable pain of the neck for the past 6 months. He has tried NSAIDs and physical therapy with no improvement. The doctor presumed degenerative disc disease and put John on a trial of a TENS unit for the past 30 days. Re-evaluation of John after the trial showed that using the TENS unit 30 minutes 4 times a day showed improvement in pain control (pain of 9 before TENS to 5 after TENS)."**

Medicines and Miscellaneous

Kohll's Rx

Enteral Nutrition

- The patient has permanent bowel impairment for at least 3 months
  - Impairment of bowel movement or bowel absorption/digestion
  - The patient requires tube feeding
- Specific documentation requirements
  - Enteral Infusion Pumps:
    - Reflux/Aspiration
    - Severe diarrhea
    - Dumping syndrome
    - Administer at <100 mL/hr
    - Fluctuations in blood sugars
    - Circulatory overload
    - Gastrostomy/jejunostomy tube used
- Special Nutrient Formulas
  - Document and send on chart specific medical condition and need for special nutrient
- Feeding supply kit – Medical necessity needs to be documented and sent with a prescription

Glucose Monitors

- Diagnosed with diabetes mellitus
- The patient is adequately trained to use the device

Additional Criteria

- Usual Utilization -
  - Uses up to 100 strips and lancets every 3 months if not being treated with insulin
  - If using insulin, uses up to 300 strips and lancets every 3 months
- High utilization –
  - The physician evaluates diabetes within 6 months of ordering an above-normal number of supplies and documents specific reason for additional need AND
  - Medical records document the frequency of actual testing
    - Justification for testing frequency
    - Document wide fluctuation of blood glucose levels
    - Copy of the patient’s blood glucose log

Continuous Glucose Monitoring System

- A continuous glucose monitoring system
  - The patient is documented to test 4 or more times per day, uses 3 or more daily insulin injections or a Medicare-covered pump
  - Insulin regimen is frequently adjusted – Needs to be recorded and documented
  - Office visit within 6 months before ordering CGM and has a follow-up appointment every 6 months

Chart Note Example: ****if requesting testing more than once per day and the patient has Type 2 Diabetes that is required every 6 months****
"John Doe has wide fluctuating blood glucose results. I've enclosed his blood glucose results over a week's period of time …….. Because of these wide fluctuations, he needs to test his blood glucose 3 times per day".

Immunosuppressive Drugs

- The drug is prescribed following a transplant
- Transplant is covered by Medicare and the patient is enrolled in part A and part B
- Prescription is sent after the procedure is complete
- **Azathioprine or Methylprednisolone parenteral**
  - Document if the patient cannot tolerate or absorb orally
  - AND can be self-administered

Oral Anti-cancer Drugs

Can only be prescribed by a physician or other practitioner licensed under state law to prescribe such drugs as anticancer chemotherapeutic agents

- Drug or biological that is approved by the FDA
- The drug or biological that is prescribed has the same chemical/generic name as the non-self-administrable anticancer chemotherapeutic drug/biological given incident to a physician's service or is the prodrug that is metabolized into the same active ingredient as the non-self-administrable drug/biological
    - **The prescribed drug/biological CANNOT be in an injectable form**
- Used for the same anticancer chemotherapeutic indication, including "off label" uses, as the non-self-administrable form of the drug
    - **The prescribed drug/biological CANNOT be used for IMMUNOSUPPRESSION**

Oral Antiemetic Drugs

- The drug and drug regimen is approved by the FDA
- Ordered as part of a cancer chemotherapy regimen
- The drug is documented to be initiated within 2 hours of chemotherapy cycle and not administered for more than 48 hours
- Covered 3-drug regimens are
  - Aprepitant/rolapitant + 5HT3 antagonist + dexamethasone
  - Netupitant/palonosetron + dexamethasone