

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Immunosuppressives Used in Organ Rejection: Prior Authorization Request Form: Please respond.

- Please complete the attached Immunosuppressives Used in Organ Rejection Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Immunosuppressives Used in Organ Rejection

Prior authorization is required to determine Medicare B or D coverage. Medicare Part B covers immunosuppressive therapy for Medicare covered transplants. The transplant is a Medicare covered transplant if the patient received it from a Medicare approved facility and was entitled to Medicare Part A at the time of the transplant. In order to process this coverage determination question 5 must be completed.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

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Prior Authorization Request Form

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Immunosuppressives Used in Organ Rejection Criteria

- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.
 ICD-9 (v42): _____
 Other (diagnosis and ICD-9 code): _____
- Formulary medication requested for PDP plans (select ONE only; complete additional form(s) for multiple drugs)
 Azathioprine tablet
 Cellcept® cap, tab, oral suspension
 Cellcept® injection
 Myfortic® cap, tab, oral suspension
 Myfortic® injection
 Prograf® cap, tab, oral solution
 Rapamune® cap, tab or oral solution
 Cyclosporine® Nonmodified cap or oral solution
 Cyclosporine® injection
 Sandimmune® cap
 Sandimmune® Nonmodified oral solution
 Sandimmune injection
 Cyclosporine Modified® cap or oral solution
 Gengraf® cap or oral solution
 Neoral® cap
 Neoral® oral solution
 Cyclophosphamide® tab
- Non formulary medication (for MA or MAPD plans only) requested:
 Cyclophosphamide® injection
 prednisone
 methylprednisolone oral
 methylprednisolone inj
 prednisolone
- Atgam
 Azathioprine injection
 Azasan
 Cytoxan
 Orthoclone
 Simulect
 Thymoglobulin
 Zenapax
- Is this medication being used for an organ transplant?
 Yes No
- If being used for an organ transplant, was this a Medicare covered transplant?
 Yes No
 Not Applicable

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____