

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



## **Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

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

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- 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

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#### 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.**

# 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: \_\_\_\_\_