

Pharmacy Prior Authorization Form

Last Reviewed: Sept. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Immunosuppressive Drugs – Oral Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Select a drug and strength:

Drug Name	Drug strength		
<input type="checkbox"/> Cellcept (mycophenolate)	<input type="checkbox"/> 250mg capsule	<input type="checkbox"/> 500mg tablet	<input type="checkbox"/> 200mg/ml suspension
<input type="checkbox"/> Imuran (azathioprine)	<input type="checkbox"/> 50mg tablet		
<input type="checkbox"/> Myfortic (mycophenolic acid)	<input type="checkbox"/> 180mg tablet	<input type="checkbox"/> 360mg tablet	
<input type="checkbox"/> Neoral (cyclosporine)	<input type="checkbox"/> 25mg capsule	<input type="checkbox"/> 100mg capsule	<input type="checkbox"/> 100mg/ml solution
<input type="checkbox"/> Prograf (tacrolimus)	<input type="checkbox"/> 0.5mg capsule	<input type="checkbox"/> 1mg capsule	<input type="checkbox"/> 5mg capsule
<input type="checkbox"/> Rapamune (sirolimus)	<input type="checkbox"/> 1mg tablet	<input type="checkbox"/> 2mg tablet	<input type="checkbox"/> 1mg/ml solution
<input type="checkbox"/> Sandimmune (cyclosporine)	<input type="checkbox"/> 25mg capsule	<input type="checkbox"/> 100mg capsule	<input type="checkbox"/> 100mg/ml solution

Priority Health precertification requirements:

Authorization of oral immunosuppressive drugs require:

- If patient received a Medicare transplant, these drugs are covered under Medicare Part B.
- If patient is using these drugs for a different FDA approved indication, they are covered under Medicare Part D.

Please Complete the Following Information:

The oral immunosuppressive drug is specifically being administered to a patient that has received a Medicare approved organ transplant.

- Yes
 No

What is the patient's diagnosis? _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX