PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Impavido (miltefosine)

Member

Last Name: ____________________ First Name: ____________________

ID #: ____________________ DOB: ____________ Gender: ____________

Primary Care Physician: ____________________

Requesting Provider: ____________________ Prov. Phone: ____________ Prov. Fax: ____________

Provider Address: ____

Provider NPI: ____________________ Contact Name: ____________________

Provider Signature: ____________________ Date: ____________

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Impavido 50mg

Start date (or date of next dose): ____________

Dose Requested: ____________

Precertification Requirements

Before this drug is covered, the patient must meet one of the following requirements:

1. Diagnosis of documented visceral, mucosal, or cutaneous leishmaniasis caused by one of the following: Leishmania donovani, Leishmania braziliensis, Leishmania guyanensis or Leishmania panamensis.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Documented visceral, mucosal or cutaneous leishmaniasis (please provide documentation)
- ☐ Leishmania donovani
- ☐ Leishmania braziliensis
- ☐ Leishmania guyanensis
- ☐ Leishmania panamensis

☐ *Other – the patient's condition is:* ____________________

Rationale for use: ____________________

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made sine 07/2016
Last reviewed 07/2018