

Medical 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.

Nulojix[®] (belatacept)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

New Request Continuation Request

Drug product: Nulojix 250 mg injection Dose: _____ Dose Frequency: _____

Start date: _____

Date of last dose: _____

Date of next dose: _____

Place of administration: Physician's office
 Outpatient infusion

Facility: _____ NPI: _____ Fax: _____

Home infusion
Facility: _____ NPI: _____ Fax: _____

Billing: Physician to buy and bill
 Facility to buy and bill
 Specialty Pharmacy

Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

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

1. Used to prevent organ rejection after kidney transplant
2. Must be used for a new kidney transplant (started on the day of transplant)
3. Patient must be Epstein-Barr virus seropositive
4. Must be used in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids
5. Patient must not be able to use tacrolimus or cyclosporine because of a drug allergy or intolerance

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- New kidney transplant
- Other, the patient's condition is: _____

B. What date did/will the patient receive his or her kidney transplant? _____

C. Is the patient Epstein-Barr virus seropositive?

- Yes
- No

D. Will Nulojix be used in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids?

- Yes
- No

E. Describe the concern for using cyclosporine or tacrolimus as an alternative therapy.

Cyclosporine:

When was cyclosporine tried? _____

What was the patient's response? _____

Tacrolimus:

When was cyclosporine tried? _____

What was the patient's response? _____