Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Nulojix® (belatacept)

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 and Billing Information

Drug product: ☐ Nulojix 250 mg injection

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

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

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

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2016
Last reviewed 11/2019