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.

Valganciclovir

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: ☐ Valganciclovir 450 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements (initial approval 1 year):

1. Must have a diagnosis of Cytomegalovirus (CMV) retinitis in HIV-infected patient and documented use in combination with Vitrasert (ganciclovir intraocular implant); OR
2. Must have diagnosis of CMV infection prophylaxis for those at high risk of CMV disease following transplantation of the heart, kidney-pancreas, or kidney.

For continuation, patient must have met the following requirements (continuation approvals 1 year):

1. Patient tolerating and responding to treatment.
2. Patient is compliant with therapy.

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.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ CMV retinitis in HIV-infected patient

☐ CMV prophylaxis in high risk patient following transplantation of heart, kidney, or kidney-pancreas

☐ *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 since 05/2018

Last reviewed 05/2018

B. If using for CMV retinitis, is the patient using in combination with Vitrasert?

- ☐ Yes
- ☐ No, *rationale:* _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ CMV retinitis in HIV-infected patient
- ☐ CMV prophylaxis in high risk patient following transplantation of heart, kidney, or kidney-pancreas
- ☐ *Other – the patient's condition is:* _____
  Rationale for use: _____

B. Has the patient responded to treatment?

- ☐ Yes
- ☐ No, *rationale for continuation:* _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2018
Last reviewed 05/2018