



IMMUNOSUPPRESSANT PRIOR AUTHORIZATION FORM

PLEASE FAX COMPLETED FORM TO: (800) 639-9158

Patient Name:	Member ID #
Date of Request:	DOB:
Requesting Physician:	DEA #
Office Phone #	Office Fax #

MEDICATION INFORMATION

<p>1. Drug Requested: <input type="checkbox"/> mycophenolate mofetil <input type="checkbox"/> tacrolimus <input type="checkbox"/> Prograf <input type="checkbox"/> cyclosporine, mod. (Neoral)** <input type="checkbox"/> Rapamune <input type="checkbox"/> cyclosporine (Sandimmune)** <input type="checkbox"/> other _____</p>
<p>2. Diagnosis: <i>(please include office notes supporting diagnosis)</i> <input type="checkbox"/> Renal transplant <input type="checkbox"/> Liver transplant <input type="checkbox"/> Heart transplant <input type="checkbox"/> other**: _____</p> <p><small>**If requesting Neoral or Sandimmune for a Non-Transplant indication, the patient must have tried and failed therapy with cyclosporine OR have a documented medical reason why cyclosporine is medically/therapeutically inappropriate.</small></p>
<p>3. Date of transplant: <i>(if applicable)</i> Was patient Medicare eligible at time of transplant? Y N</p>
<p>4. Other Supporting Information:</p>
<p>Physician's Signature:</p>
<p>Physician's Specialty:</p>

CHCH 2007-2(12/09)

For Urgent Requests please call (800) 551-2694

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