Medication Prior Authorization Form

Fax to 1-866-240-8123

Transplant Rejection Prophylaxis Medications

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Drug Name	Drug Strength	Requested Quantity	Requested Day Supply ☐ 30 days ☐ 90 days ☐ Other: _____
Directions			
Diagnosis and/or ICD-10 code(s)			
1. Brand Medically Necessary?		Yes	No
If **YES**:			
1a. Is the member stable on the requested medication?		Yes	No

Clinical Information:

1. Is this medication being used as part of a post-transplant immunosuppressive regimen?	Yes	No

If **YES**:

1a. Please select the member's transplant type:

☐ Liver ☐ Heart ☐ Kidney ☐ Lung

☐ Other transplant (please provide): _____

☐ Other diagnosis with ICD-10 Code: _____

2a. Please provide the date of the member's most recent transplant: _____

3a. Please provide the most recent transplant payer (if known):

☐ Medicare ☐ Commercial

- If Medicare, please provide the member's Part A effective date (if known): _____

2. Please provide any other medications that the member has tried and failed:

_____

_____

_____

3. Please provide any additional information pertinent to this request:

_____

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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