



**Attention: IMMEDIATE ACTION REQUESTED**  
**Prior Authorization DENIAL** may occur unless complete information is provided

Reference: [PA#]

**General Prior Authorization Form: Immunosuppressive Therapy**

FAX COMPLETED FORM TO QHP PHARMACY DEPT. Fax # 877-817-0842

**Coverage Criteria** (guidance for Question 1 taken from Medicare Prescription Drug Benefit Manual, “Chapter 6-Appendix C-Summary of Coverage Policy” Attachment 1):

**-Other Criteria:** This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Member Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Member ID#		NPI or DEA#:	
DOB:		Office Phone:	Office Fax:
Address:		Address:	
Home Phone:		Contact Person:	
Medication Information		Medical Information	
Medication Requested (drug name, strength and route of administration):		Drug Allergies:	
Medication Details (frequency, quantity):		Diagnosis:	
Expected Length of Therapy:		Prescriber’s Signature/Date:	

**Rationale for Prior Authorization**

1. Has patient received a transplant? (check one)     Yes     No
  - Was patient enrolled in Medicare at time of transplant? (check one)     Yes (Part B)     No (Part D)
  
2. Has patient taken this medication in the past? (check one)     Yes     No
  - If yes, for how long: \_\_\_\_\_
  - If yes, how did patient receive medication (samples, alternate coverage, etc.)? \_\_\_\_\_
  
3. Please list other medications attempted for this patient:
 

Medication: _____	Reason therapy failed: _____	Length of therapy: _____
_____	_____	_____
  
4. Additional comments: \_\_\_\_\_  
 \_\_\_\_\_
  
5. PLEASE INCLUDE RELEVANT MEDICAL RECORDS AND LAB REPORTS WITH YOUR REQUEST.

For Expedited Requests please call 1-877-233-7058  
 Our Formulary List is located at <http://www.qualityhealthplansny.com>

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