QHP
Quality Health Plans of New York
A Medicare Advantage Plan

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