FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Transplant & Immunosuppressant Drug Therapy Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Provide the diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Has the patient had a transplant from a Medicare-approved facility? ❑ **Yes** ❑ **No**

Was the patient eligible for Medicare Part A at the time of the transplant? ❑ **Yes** ❑ **No**

For Nulojix requests, also answer the following:

Is this request for continuous therapy with Nulojix? ❑ **Yes** ❑ **No**

Is Nulojix being used for prophylaxis of organ rejection in adults receiving a kidney transplant, in combination with Simulect (basiliximab) induction, Cellcept (mycophenolate mofetil), and corticosteroids? ❑ **Yes** ❑ **No**

Is Nulojix being prescribed by a nephrologist or transplant specialist? ❑ **Yes** ❑ **No**

Is the patient a transplant recipient who is Epstein-Barr virus seronegative or with unknown Epstein-Barr virus serostatus? ❑ **Yes** ❑ **No**

Medication history:

For Cellcept and Myfortic, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Generic mycophenolate mofetil
- ❑ Generic mycophenolic acid delayed-release
- ❑ Other drugs in the same class. Please specify: _____
- ❑ Other therapeutic equivalent alternatives. Please specify: _____

For Imuran, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Azasan
- ❑ Generic azathioprine
- ❑ Other drugs in the same class. Please specify: _____
- ❑ Other therapeutic equivalent alternatives. Please specify: _____

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Coverage Determination Request Form (Page 2 of 2)

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For Neoral, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Generic cyclosporine
- ❑ Generic cyclosporine modified
- ❑ Gengraf
- ❑ Sandimmune
- ❑ Other drugs in the same class. Please specify: _____
- ❑ Other therapeutic equivalent alternatives. Please specify: _____

For oral Prograf, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Astagraf XL
- ❑ Envarsus XR
- ❑ Generic tacrolimus
- ❑ Other drugs in the same class. Please specify: _____
- ❑ Other therapeutic equivalent alternatives. Please specify: _____

For Rapamune tablets, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Generic sirolimus
- ❑ Rapamune solution
- ❑ Other drugs in the same class. Please specify: _____
- ❑ Other therapeutic equivalent alternatives. Please specify: _____

For Sandimmune capsules, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Generic cyclosporine
- ❑ Generic cyclosporine modified
- ❑ Gengraf
- ❑ Sandimmune oral solution
- ❑ Other drugs in the same class. Please specify: _____
- ❑ Other therapeutic equivalent alternatives. Please specify: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.