



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

### Zortress® Prior Authorization Request Form

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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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

#### Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

#### Clinical Information (required)

**Select the diagnosis below:**

Prophylaxis of organ rejection in kidney transplantation

Prophylaxis of organ rejection in liver transplantation

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Provider's Specialty:**  
Is the prescriber experienced in immunosuppressive therapy and management of transplant patients?  Yes  No

**For prophylaxis of organ rejection in kidney transplantation, answer the following:**  
Is the medication being used for prevention of kidney transplant organ rejection?  Yes  No  
Is the patient at low-to-moderate immunologic risk?  Yes  No  
Select if the patient is prescribed concurrent therapy with reduced doses of the following:  
 Cyclosporine  
 Corticosteroids

**For prophylaxis of organ rejection in liver transplantation, answer the following:**  
Is the medication being used for prevention of liver transplant organ rejection?  Yes  No  
Have thirty (30) or more days passed since the transplant procedure?  Yes  No  
Select if the patient is prescribed concurrent therapy with reduced doses of the following:  
 Tacrolimus  
 Corticosteroids

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

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

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