PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

Transplant Rejection Prophylaxis Medications

Member/Provider Information:

Subscriber ID Number			Group Number
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code
Physician Name	Phone		Fax
Physician Address with Suite / Building	City	State	Zip Code
NPI	Physician Signature		Date

Clinical Information:

Medication Requested: _____ Dose and Quantity Requested: _____

Brand Medically Necessary? Yes / No

Documentation of Medical Necessity:

1. Please select the patient's transplant type:
   - ☐ Liver
   - ☐ Kidney
   - ☐ Heart
   - ☐ Lung
   - ☐ Other transplant (please provide): _____
   - ☐ Other diagnosis with ICD-10 Code: _____

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

3. Please provide the most recent transplant payer (if known):
   - ☐ Commercial
   - ☐ Medicare
     - If Medicare, please provide the patient's Part A effective date (if known): _____

4. If Brand Medically Necessary, please provide clinical rationale: _____

5. Please provide any previous medications used for the provided diagnosis and any other 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 patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.