

# OPTIMA MEDICARE

## Pharmacy Prior Authorization Request Form\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.

### IMMUNOSUPPRESSANTS

**Azathioprine, Cellcept® (mycophenolate mofetil), cyclosporine, Imuran® (azathioprine), Myfortic® (mycophenolate), Neoral® (cyclosporine), Prograf® (tacrolimus), Sandimmune® (cyclosporine), Azasan® (azathioprine), Rapamune® (sirolimus)**

- Coverage for drugs used for immune suppression post-transplant is dependent upon what insurer paid for the transplant.
- If Medicare paid for the member's transplant, the drugs are covered under the Medicare Part B benefit.
- If another insurer paid for the member's transplant, the drugs are covered under the Prescription Drug Benefit (Part D).
- Any other potential approved uses of immunosuppressants would be covered under the Part D benefit.

Member has received a transplant paid for by: (Please check appropriate box)

- Medicare (drugs covered under Part B)
- Another insurer, including Medicaid (drugs covered under Part D)

Patient Name \_\_\_\_\_

Member Number \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_

Physician Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Pharmacy Tel # \_\_\_\_\_ (If available)