

Bravo Health

Coverage Review / Prior Authorization Request Form



Immunosuppressant Medications

Atgam, Thymoglobulin, Imuran, Cyclosporine, Zenapax, Orthoclone OKT3, Cellcept, Rapamune, Prograf, Myfortic

Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	
Diagnosis and Medication Requested			
Medication Requested (dosage, frequency):		Qty:	
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:	
Clinical Criteria			
Please answer the following questions:			
1. Is the immunosuppressant medication being used subsequent to an organ transplant?			
Yes No			
If yes, to question #1, please continue:			
2. Did Medicare pay for the transplant?			
Yes No			
3. What was the date of the transplant? _____			
4. Has coverage for the requested medication been sought and denied under Part B benefit?			
Yes* No			
5. If available, please include copy of member's Medicare Part A & B insurance card.			
*Documentation must be provided if an insurer other than Medicare provided payment for the transplant or immunosuppressant medication coverage has been sought and denied under Medicare Part B.			
**Failure to provide adequate documentation could result in denial of this request.			
Additional Comments/Explanation:			
Request for Expedited Review			
<input type="checkbox"/>	REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION		

Prescriber's Signature: _____

Date: _____

Fax back to: 866-464-0709

For info call: 877-813-5595

For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>