

FLORIDA MEDICAID PRIOR AUTHORIZATION

Cytogam[®]

CVS caremark*

(Maximum Length of Therapy is 16 Weeks)

Note: Form must be	e completed in full	. An incomplete form ma	y be returned
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Recipient's Med	icaid I	D#							Date	e of E	Birth	(MN	I/DD/	YYY	Y)				1							
											1			1												
Recipient's Full Name																										
Prescriber's Full Name																										
Prescriber's NPI	_						1																			
Prescriber Phon	scriber Phone Number Prescr									crib	riber Fax Number															
-				-														-				-				
Pharmacy Name									_																	
Pharmacy Medic	aid P	rovide	er#																	1						
Pharmacy Phone	e Num	nber										1			Pha	rmac	y Fa	x Nu	mbe	er						
-				-														_				-				
1. Indicate which transplant organ the recipient received.																										
🗌 Kidn] Lui	-] Liv				Par	crea	as] Hea	art										
2. Did the transplant organ come from a cytomegalous seropositive donor?																										
 Was the recipient at the time of the transplant a cytomegalous seronegative recipient? Yes No 																										
4. What was the date of the transplant?																										
5. What is the	5. What is the patient's weight? lbs									kg																
6. What is the date range of therapy? Begin Date:						ite:_		End Date):										
7. What will be the dosage and frequency of dosing?																										
Prescriber's Signature:															I	Date	:									

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Call or Fax Information to: Florida Community Care Prior Authorization

Phone number for non-specialty Prior Authorization: 877-433-7643 Phone number for specialty Prior Authorization: 866-814-5506 Fax number for non-specialty Prior Authorization: 866-255-7569 Fax number for non-specialty Prior Authorization: 866-249-6155 **Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited. Page 1 of 2



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Approval Indications:

- Diagnosis of active cytomegalovirus disease associated with transplantation of the kidney, lung, liver, pancreas, or heart organ.
- Transplant organ must come from a cytomegalous seropositive donor to a cytomegalous seronegative recipient.

Approval Period:

• Maximum of 16 weeks.