

FLORIDA MEDICAID PRIOR AUTHORIZATION **Cytogam**<sup>®</sup>



(Maximum Length of Therapy is 16 Weeks)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#	Date of Birth (MM/DD/YYYY)
Desiniantle Full Name	
Recipient's Full Name	
Prescriber's Full Name	
Prescriber's NPI	
Prescriber Phone Number	Prescriber Fax Number
Pharmacy Name	
Pharmacy Medicaid Provider #	
Pharmacy Phone Number	Pharmacy Fax Number
1. Indicate which transplant organ the recipient	received.
Kidney Lung Liver	Pancreas Heart
2. Did the transplant organ come from a cytom	egalous seropositive donor?
3. 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 patient's weight?	lbs kg
6. What is the date range of therapy? Begin	Date: End Date:
7. What will be the dosage and frequency of dosing?	
7. What will be the dosage and hequency of d	onig
Prescriber's Signature:	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

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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.