

FAX TO : 1-800-459-2135

Health Information Designs, Inc.
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Phone 800-355-0486

IMMUNOSUPPRESSANT

PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid # _____

DOB: _____ City _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ NPI #: _____
Medicaid ID # _____

City _____ State _____ Phone #: _____

FAX #: _____

Physician's signature and date

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider # _____

City _____ State _____ Phone #: _____

FAX #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____ Quantity /Month _____ Daily Dose: _____ mg/day

Diagnosis: _____ NDC#: _____

Additional Medical Information: _____

Use is for kidney, liver or heart allogenic transplant, YES ___ NO ___
rheumatoid arthritis, psoriasis, nephrotic syndrome or
Stevens-Johnson syndrome.

Prescribing physician is experienced in the management YES ___ NO ___
of transplant patients and in immunosuppressive therapy.

Blood levels are monitored regularly while patient is on oral therapy. YES ___ NO ___

*Medicare is to be billed first if beneficiary is dually eligible.

FOR HID USE ONLY

Eligibility Verified by _____

Approved _____

Denied/Code: _____

From Date _____ Thru Date _____

Reviewed by _____

HID# _____ PA# _____