maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Livtencity

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient greater than or equal to 12 year(s) of age? [If no, no further questions.]	Yes	No
2	What is the diagnosis or indication? [] Cytomegalovirus infection (If checked, go to 3) [] Other (If checked, no further questions)		
3	Is the patient's weight 35 kg or more? [If no, no further questions.]	Yes	No
4	Is the patient post-transplant? [Note: This includes patients who are post-hematopoietic stem cell transplant (HSCT) or post-solid organ transplant (SOT).]	Yes	No

If you have any questions, call:
1-888-258-8250

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	[If no, no further questions.]		
5	Has documentation been submitted to confirm that the patient has a diagnosis of cytomegalovirus infection/disease that is refractory to treatment with at least one of the following: cidofovir, foscarnet, ganciclovir, or valganciclovir, unless intolerant to all medications listed? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Has documentation been submitted to confirm that the patient has failed to achieve GREATER THAN 1 log 10 decrease in cytomegalovirus (CMV) DNA level in whole blood or plasma after MORE THAN 14 days of treatment with AT LEAST 2 medications such as cidofovir, foscarnet, ganciclovir, or valganciclovir? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Is the requested medication being prescribed in conjunction with ganciclovir or valganciclovir? [If yes, no further questions.]	Yes	No
8	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [If yes, no further questions.]	Yes	No
9	Does the patient have a diagnosis of cytomegalovirus (CMV) disease that involves the central nervous system, including CMV retinitis? [If yes, no further questions.]	Yes	No
10	Is the requested medication being prescribed by or in consultation with a hematologist, infectious diseases specialist, oncologist, or a transplant physician? [If no, no further questions.]	Yes	No
11	Does the prescriber attest that the medication is not being used for the prevention of cytomegalovirus (CMV) infection? [If no, no further questions.]	Yes	No
12	If the patient is not responding to treatment, does the provider agree to monitor cytomegalovirus (CMV) DNA levels and check for resistance?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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