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MAGELLAN COMPLETE CARE

Prior Authorization

Cytogam®

Maximum Length of Therapy = 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) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

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 cytomegalous seropositive donor? ○ Yes ○ No

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? _____

Date

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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

Magellan Complete Care

MCC Physician Review: ○ I do not recommend Approval. ○ I recommend Approval for _____ months.

MCC Physician Signature: _____ **Date:** _____

Fax or mail completed forms to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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