



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Azathioprine (Medicare B vs. D)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Azathioprine (Medicare B vs. D).

Drug Name (select from list of drugs shown)

Azasan (azathioprine)

Azathioprine

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Has the patient undergone an organ transplant? | Y | N |
| [If the answer to this question is no, then no further questions required.] | | |
| 2. Was the patient enrolled in Medicare Part A at the time of the transplant? | Y | N |
| [If the answer to this question is no, then no further questions required.] | | |
| 3. Is this drug part of an immunosuppressive regimen for an organ transplant? | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date