



Prior Authorization Form

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

**Drug Name (select from list of drugs shown)**  
Cellcept (mycophenolate mofetil)

**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**