Prior Authorization Form

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

Drug Name (select from list of drugs shown)
Neoral (cyclosporine)

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.

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Prescriber (Or Authorized) Signature and Date