



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

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

Drug Name (select from list of drugs shown)

Rapamune (sirolimus)

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