

Prograf® (tacrolimus) Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Prophylaxis of organ rejection in cardiac (heart) transplant	
<input type="checkbox"/> Prophylaxis of organ rejection in hepatic (liver) transplant	
<input type="checkbox"/> Prophylaxis of organ rejection in renal (kidney) transplant	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient used Prograf/tacrolimus in the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For oral brand Prograf requests, select if the patient has history of failure, contraindication, or intolerance to the following:	
<input type="checkbox"/> Astagraf XL	
<input type="checkbox"/> Envarsus XR	
<input type="checkbox"/> Generic tacrolimus	
For transplant, also answer the following:	
Has the patient received a heart, liver, or kidney transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (please specify organ): _____	
Date of transplant: _____ (mm/dd/yyyy)	
Did the transplant occur in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.
Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.



1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

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I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ Date: _____

PROACT INTERNAL USE ONLY:				
Clinical Review Decision				
Approved, through				
Denied (documentation attached, if necessary)				
Tracking:				
1 st Attempt		2 nd Attempt		Letter Mailed: