



Immunosuppressants

Express Scripts
Prior Authorization
Phone 800-417-8164
Fax 877-837-5922

Member's Last Name	Member's First Name
VH ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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1. **What is the diagnosis or indication? (Please specify the type of transplant received and the date it occurred).**

a. **Was the patient eligible for Medicare at the time of the transplant?**

2. **Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.