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United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

Cytogam®

(Maximum Length of Therapy is 16 Weeks)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number - -

Pharmacy Fax Number - -

1. Indicate which transplant organ the recipient received.
   ☐ Kidney ☐ Lung ☐ Liver ☐ Pancreas ☐ Heart
2. Did the transplant organ come from a cytomegalous seropositive donor?
   ☐ Yes ☐ No
3. Was the recipient at the time of the transplant a cytomegalous seronegative recipient?
   ☐ Yes ☐ No
4. What was the date of the transplant? _____
5. What is the patient's weight? _____ lbs _____ kg
6. What is the date range of therapy? **Begin Date**:_____ **End Date**:_____
7. What will be the dosage and frequency of dosing? _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:

1-855-258-1593

02.15.2024

Approval Indications:

- Diagnosis of active cytomegalovirus disease associated with transplantation of the kidney, lung, liver, pancreas, or heart organ.
- Transplant organ must come from a cytomegalous seropositive donor to a cytomegalous seronegative recipient.

Approval Period:

- Maximum of 16 weeks.