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 License # (ME, OS, ARNP, PA)

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: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.
The provider must retain copies of all documentation for five years.

Fax Information to:

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727

Approval Indications:

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

Approval Period:

Maximum of 16 weeks.