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# Nulojix® Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| 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: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Prophylaxis of organ rejection in renal (kidney) transplant

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical Information:**

Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**

Has the patient used Nulojix in the past 120 days? ❑ **Yes** ❑ **No**

Is Nulojix being used for prophylaxis of acute organ rejection of transplanted renal (kidney) allograft? ❑ **Yes** ❑ **No**

Other (please specify organ): _____

Date of transplant: _____ (mm/dd/yyyy)

**Please note: The date provided will be used only in the absence of Medicare-provided data.*

Is the patient immune to the Epstein-Barr virus (i.e., EBV seropositive)? ❑ **Yes** ❑ **No**

Will Nulojix be used with corticosteroids? ❑ **Yes** ❑ **No**

Will Nulojix be used with mycophenolate? ❑ **Yes** ❑ **No**

Is Nulojix prescribed by a kidney transplant specialist? ❑ **Yes** ❑ **No**

Is the prescriber experienced in immunosuppressive therapy and management of transplant patients? ❑ **Yes** ❑ **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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.