



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for 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: 1-800-310-6826

02.01.2025

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**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.