HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

LONG ACTING TACROLIMUS

Astagraf XL®, Envarsus XR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: ☐ Astagraf XL® (tacrolimus extended-release), ☐ Envarsus XR® (tacrolimus extended-release)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section			
Questions	**Yes**	**No**	**Comments/Notes**
1. Will tacrolimus extended-release be used for the prevention of organ rejection in a kidney transplant recipient?	☐	☐	
2. Will tacrolimus extended-release be in used in combination with other immunosuppressants?	☐	☐	
3. Is the requesting provider a nephrologist or transplant specialist?	☐	☐	
4. Is the member on a stable dose of tacrolimus immediate release with whole blood trough concentrations at goal?	☐	☐	**Please provide documentation**
5. Has the member had at least a 3-month trial and failure or intolerance/contraindication to immediate-release tacrolimus?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with an improvement or stabilization in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

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Policy: PHARM-CHIP-043
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024