MC-Rx
Powered by ProCare Rx

Valcyte® Valganciclovir

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Valcyte®** Valganciclovir. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:	Plan Name/Plan ID:		
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:	

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information.)		
Directions:	Qty/30 Days:	Weight: As of: (date)

☐ **Initiation of Therapy** **OR** ☐ **Continuation of Therapy**

Official supporting medical documentation (evaluation and progress notes) must be submitted.

1. Check all boxes that apply:

   ☐ CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS):
   CD4 Count: (most recent) _____ Date of Lab: _____/_____/_____
   CMV retinitis: ☐ Active ☐ Inactive CMV Status: ☐ Positive ☐ Negative

   ☐ CMV prophylaxis in patients at high risk for CMV disease following heart, kidney, and kidney-pancreas transplants.
   Date of transplant: _____/_____/_____ Type of transplant: _____
   Donor: ☐ Positive ☐ Negative Recipient: ☐ Positive ☐ Negative

2. Is patient receiving peritoneal hemodialysis? YES NO

3. Current or previous therapy to treat infection in the past 90 days:
   Medication Name: _____ Start Date: _____ End Date: _____
   Reason for Discontinuing: _____
   Medication Name: _____ Start Date: _____ End Date: _____
   Reason for Discontinuing: _____
   Medication Name: _____ Start Date: _____ End Date: _____
   Reason for Discontinuing: _____

4. Does this patient currently have any of the following comorbidities? **(submit labs)** YES NO
   ☐ Platelet Count < 25,000/mm³ (µL) ☐ Hemoglobin <8g/dl ☐ Absolute Neutrophil Count (ANC) < 500/mm³ (µL)

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.