

**PRIOR AUTHORIZATION REQUEST FORM**
**LONG ACTING TACROLIMUS**

 Astagraf XL<sup>®</sup>, Envarsus XR<sup>®</sup>

**For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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<sup>®</sup> (tacrolimus extended-release),  Envarsus XR<sup>®</sup> (tacrolimus extended-release)

Dosing/Frequency: \_\_\_\_\_

**If the request is for reauthorization, proceed to reauthorization section**

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will tacrolimus extended-release be used for the prevention of organ rejection in kidney transplant recipients?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Will tacrolimus extended-release be in used in combination with other immunosuppressants?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the requesting provider a nephrologist or transplant specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the patient on a stable dose of tacrolimus immediate release with a whole blood trough concentrations at goal?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the patient had at least a 3 month trial and failure to, intolerance or contraindication to, an immediate-release tacrolimus?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**REAUTHORIZATION**

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with an improvement or stabilization in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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**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:

**\*\*Failure to submit clinical documentation to support this request will result in delay and/or denial of the request\*\***

Policy PHARM- 043  
Origination Date: 08/23/2018  
Reviewed/Revised Date: 01/22/2020  
Next Review Date: 01/23/2021  
Current Effective Date: 01/23/2020

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