Print Form Reset Form

FLORIDA MEDICAID

Prior Authorization

Valcyte® *(Valganciclovir)*

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number -

Prescriber Fax Number -

☐ Valcyte (Valganciclovir) ◯ Initiation of therapy ◯ Continuation of therapy			_____ lbs _____ kgs
	Directions	*Quantity/30 Days*	*Weight*

1. Please check all boxes that apply: (OFFICIAL SUPPORTING MEDICAL DOCUMENTATION [Evaluation and Progress Notes] MUST BE SUBMITTED.)

☐ 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

☐ **Other**: _____

(Refer these requests only to AHCA at fax number 800-332-1024)

2. Is the 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)

Prescriber's Signature: _____ DATE : _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs

The provider must retain copies of all documentation for five years.

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727