

Prescriber Criteria Form

Nulojix 2024 PA Fax BD-26 v1 010124.docx
Nulojix (belatacept)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Nulojix (belatacept).

Drug Name:
Nulojix (belatacept)

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Is the requested drug being administered in the home (e.g., PATIENT'S HOME, NOT A FACILITY)? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being used as a component of an immunosuppressive regimen for an organ transplant? [Tech Note: If the answer to this question is yes, please see work instructions to complete B vs D determination.]	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____