

Prior Authorization Request Form for ZOSTAVAX

Please Fax completed Form to the Pharmacy Services Department at (505) 923-5540 or 1-800-724-6953	For help with this Form, please call (505) 923-5757 or toll-free 1-888-923-5757, option 3
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MEMBER INFORMATION		
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Member's Name:	Member's ID Number:	
Social Security Number:	Member's Date of Birth:	Member's Age:

Medication Requested:
Drug: Zostavax (<i>zoster vaccine, live</i>) Dosing: .065ml SQ x 1 dose

ZOSTAVAX PHARMACY EXCEPTION CRITERIA

1. Patient must be greater than or equal to 50 years of age.
2. Patient does not have a contraindication to use Zostavax, such as:
 - Immunosuppression; or
 - Active Zoster infection

PHYSICIAN INFORMATION

Physician Name (<i>please print</i>):			NPI Number:
Address:			Phone Number:
			Fax Number:
<input type="checkbox"/> Medicare Part D	<input type="checkbox"/> Non Medicare	<input type="checkbox"/> Bill Medical	Confirmed Copay Amount: \$ _____
Physician Signature (<i>required</i>):			HIPAA Notification: <input type="checkbox"/> Yes <input type="checkbox"/> No

FOR PRESBYTERIAN PHARMACY SERVICES DEPARTMENT USE ONLY

Reviewed by:	Date:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
Medical Director:	Date:	<input type="checkbox"/> ASO:	<input type="checkbox"/> SALUD
		<input type="checkbox"/> Commercial	<input type="checkbox"/> SCI
Comments:		<input type="checkbox"/> PIC	<input type="checkbox"/> Senior Care

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