



Candidas
(Caspofungin)

Prior Authorization Form
Curascript
Fax (888) 773-7386

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.)			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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1. Is the diagnosis or indication for the treatment of one of the following:

- Candidemia
- Esophageal candidiasis
- Fungal infections
- Invasive aspergillosis

2. Has the diagnosis been confirmed by laboratory testing?

3. Is the prescription recommended or initially written by an Infectious Disease Specialist?

4. Is Candidas being administered through one of the following: the Home Health, physician's office or outpatient services?

5. Is Candidas being provided by a Home Infusion Pharmacy?

6. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

For Internal Use Only

Approved Denied Reviewer's Initials _____ Decision Date _____

Comments _____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.