



Vidaza (Azacitidine)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: 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) [] Physician [] 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

1. Is the initial prescription written or recommended by an Oncologist/Hematologist ?
2. Is the diagnosis or indication for the treatment of one of the following:
[] Myelodysplastic syndrome subtypes: refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, refractory with excess blasts in transformation, and chronic myelomonocytic leukemia
[] Refractory Acute Lymphocytic Leukemia
[] Refractory Acute Myelogenous Leukemia
3. Is Vidaza being administered through one of the following: the Home Health, Physician's Office or Outpatient services?
4. Is Vidaza being administered by the patient or a caregiver at home?
5. Are there any other comments, diagnoses, symptoms, and/or any other information 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.