# Adagen (Pegademase Bovine)

# 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:**<br>Shipping Address (if different from home address)<br>☐ 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 diagnosis or indication for the treatment of severe Adenosine deaminase deficiency?**
2. **Has the diagnosis been confirmed by laboratory or genetic testing?**
3. **Is the patient a candidate for bone marrow transplant?**
4. **Has the patient failed bone marrow transplant?**
5. **Is medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?**
6. **Is the medication supplied and administered by a Physician's office?**
7. **Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels 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.