



Carimune
(Immune Globlin)

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
---	-------	-----------------	-----------	--------------

This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

1. Does the patient have a diagnosis of primary immune deficiency disease?
2. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?
3. Will this medication be administered for any FDA-approved indication?
4. Is the medication supplied and administered by a Physician's office?
5. 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: _____
------------------------------	------------------	-------------

<u>For Internal Use Only</u>	
<input type="checkbox"/> Approved <input type="checkbox"/> 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>.