



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
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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- Is the diagnosis or indication for the treatment of one of the following: Empirical therapy for presumed fungal infections in febrile, neutropenic patients, Candidemia, Esophageal candidiasis, or invasive aspergillosis?**
- Has the diagnosis been confirmed by laboratory testing?**
- Is the prescription recommended or initially written by an Infectious Disease Specialist?**
- Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?**
- Is the medication supplied and administered by a Physician's office?**
- 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: _____
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<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>.