



Elitek (rasburicase)

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 diagnosis or indication for the treatment of one of the following:
a. The initial management of plasma uric acid levels in pediatric patients with leukemia, lymphoma, and solid tumor malignancies who are receiving anti-cancer therapy expected to result in tumor lysis and subsequent elevation of plasma uric acid.
b. Prevention and reduction of chemotherapy-induced tumor lysis syndrome and elevated plasma uric acid concentrations in adults with leukemia, lymphoma, or solid tumors.
2. Is the prescription recommended or initially written by an Oncologist or Hematologist?
3. Does the patient have glucose-6-phosphate dehydrogenase (G6PD) deficiency?
4. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?
5. Is the medication supplied and administered by a Physician's office?
6. 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.