



**Prior Authorization Form  
Curascript  
Fax (888) 773-7386**

**Ontak  
(Denileukin Diffitox)**

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			
<b>For Specialty Medications Only:</b> 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
---	-------	-----------------	-----------	--------------

- |  |
|--|
| 1. Is the diagnosis or indication for the treatment of patients with persistent or recurrent cutaneous T-cell lymphoma? If no continue to #3                           |
| 2. Does the patient's malignant cells express CD25 component of IL-2 receptor confirmed by laboratory testing?   |
| 3. Is the diagnosis or indication for one of the following:<br>a. Treatment of chronic lymphocytic leukemia refractory to fludarabine<br>b. Non-Hodgkin lymphoma       |
| 4. Is the prescription recommended or initially written by an Oncologist or Hematologist who is experienced in the use of antineoplastic therapy?                      |
| 5. Are the following laboratory tests performed prior to initiation of Ontak: CBC, blood chemistry panel, including liver and renal function and serum albumin levels? |
| 6. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?  |
| 7. Is the place where medication will be administered equipped for cardiopulmonary resuscitation and where the patient is closely monitored?                           |
| 8. Is the medication supplied and administered by a Physician's office?  |
| 9. 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>.