



Proleukin
(Aldesleukin)

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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1. Is the initial prescription written or recommended by an Oncologist or other specialist?
2. Is the diagnosis or indication for the treatment of one of the following: <input type="checkbox"/> Metastatic Renal Cell Carcinoma <input type="checkbox"/> Metastatic Melanoma <input type="checkbox"/> HIV [in combination with highly active antiretroviral therapy (HAART)] <input type="checkbox"/> In combination for treatment of cutaneous T-cell lymphoma <input type="checkbox"/> Colorectal Cancer <input type="checkbox"/> Non-Hodgkin Lymphoma <input type="checkbox"/> Acute Myelogenous Leukemia (AML) <input type="checkbox"/> Autologous Bone Marrow Transplantation (ABMT)
3. Is the patient's ECOG performance status greater than 1?
4. Are the patient's cardiac and pulmonary functions within normal limits as defined by thallium stress testing and pulmonary function testing?
5. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies and administered under the supervision of a specialist experienced in the use of anticancer agents?
6. Is the medication supplied and administered by a Physician's office?
7. 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 _____
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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>.