



**Velcade
(Bortezomib)**

**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
---	-------	-----------------	-----------	--------------

1. Is the initial prescription written or recommended by an Oncologist?
2. Is the diagnosis or indication for the treatment of Multiple Myeloma or with Mantle Cell Lymphoma?
3. Has the patient experienced disease progression with at least one prior therapy for the current condition? Therapy Tried: _____ Dates: _____
4. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies and administered by the Healthcare Professional's supervision experienced in the use of antineoplastic therapy?
5. Is the medication supplied by a Physician's office?
6. Are there any other comments, diagnoses, symptoms, and/or any other information you feel 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>.