



Adagen
(Pegademase Bovine)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
Fax 877-837-5922

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
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1. Is the diagnosis or indication for enzyme replacement therapy for adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID)?
2. Has the diagnosis been confirmed by Immunologic, or Imaging or genetic testing?
3. Is the patient a candidate for bone marrow transplant?
4. Has the patient failed bone marrow transplant?
5. Is the patient a candidate for HLA identical bone marrow transplant therapy?
6. Will Adagen be used as a replacement for continued close medical supervision and the initiation of appropriate diagnostic tests and therapy (e.g., antibiotics, nutrition, oxygen, gammaglobulin), as indicated for intercurrent illnesses?
7. Is medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?
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	
<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>.