



**Anagrelide**  
(Anagrelide)

**Express Scripts**  
**Prior Authorization**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

**Please have the information below ready when calling in the authorization.**

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:
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<b>1. Is the patient diagnosed with essential thrombocythemia secondary to myeloproliferative disorders, to reduce the elevated platelet count and the risk of thrombosis and to ameliorate associated symptoms?</b>
<b>2. Is the prescription being prescribed by an Oncologist/Hematologist?</b>
<b>3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b>

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>.