



Mitoxantrone
(mitoxantrone)
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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This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

<p>1. Is the diagnosis or indication for one of the following:</p> <ul style="list-style-type: none"> a. <u>Acute nonlymphocytic leukemia:</u> In the initial therapy of acute nonlymphocytic leukemia (ANLL) in adults in combination with other approved drug(s). This category includes myelogenous, promyelocytic, monocytic, and erythroid acute leukemias b. For reducing neurologic disability and/or the frequency of clinical relapses in patients with <u>secondary</u> (chronic) progressive, progressive relapsing, or worsening relapsing remitting <u>Multiple Sclerosis (MS)</u> (e.g., patients whose neurologic status is significantly abnormal between relapses). c. <u>Prostate cancer:</u> As initial chemotherapy for the treatment of patients with pain related to advanced hormone-refractory prostate cancer in combination with corticosteroids <p>If yes, continue to #3 If no, continue to #2</p>
<p>2. Is the diagnosis or indication for the treatment of patients with primary progressive Multiple Sclerosis (MS)?</p>
<p>3. Is the medication supplied by Retail, Home Infusion, Long Term Care (LTC) or other pharmacies?</p>
<p>4. Is the medication supplied and administered by a Physician's office?</p>
<p>5. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</p>

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 _____	