Anti-Cancer Drugs: cyclophosphamide oral methotrexate inj

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

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:

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.

1. **Is the diagnosis or indication for this medication Cancer?**

2. **Will this medication be used for any other FDA-approved indication?**

3. **Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

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.