



Neutrexin
 (Trimetrexate Glucronate)
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
---	-------	-----------------	-----------	--------------

- 1. Is the diagnosis or indication for the treatment of Moderate-to-Severe Pneumocystis Carinii Pneumonia?**
- 2. Has the patient tried and failed or intolerant to trimethoprim-sulfamethoxazole therapy or does the patient have contraindications to this medication?**
- 3. Is Neutrexin being administered with concurrent Leucovorin therapy?**
- 4. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?**
- 5. Is the medication supplied and administered by a Physician's office?**
- 6. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that 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 _____	