Cancidas
(Caspofungin)

Prior Authorization Form
Curascript
Fax (888) 773-7386

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	
VH ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ 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 one of the following:**
   - ☐ **Candidemia**
   - ☐ **Esophageal candidiasis**
   - ☐ **Fungal infections**
   - ☐ **Invasive aspergillosis**
2. **Has the diagnosis been confirmed by laboratory testing?**
3. **Is the prescription recommended or initially written by an Infectious Disease Specialist?**
4. **Is Cancidas being administered through one of the following: the Home Health, physician's office or outpatient services?**
5. **Is Cancidas being provided by a Home Infusion Pharmacy?**
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:

For Internal Use Only
☐ Approved ☐ 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.