



**Intron-A**  
(interferon alfa-2b)

**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
VH ID number	Date of Birth	Est. Start Date	Office Contact
<b>For Specialty Medications Only:</b> 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.	<b>Does the patient have a diagnosis of one of the following:</b>  <input type="checkbox"/> Hairy cell leukemia <input type="checkbox"/> AIDS-related Kaposi's sarcoma <input type="checkbox"/> Chronic hepatitis C <input type="checkbox"/> Chronic myelogenous leukemia
2.	<b>Is the prescribing physician a Gastroenterologist, Infectious Disease specialist, or an Oncologist?</b>
3.	<b>Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b>

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 _____	

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>.