



Proleukin
(Aldesleukin)

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) <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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1. Is the initial prescription written or recommended by an Oncologist or other specialist?
2. Is the diagnosis or indication for the treatment of one of the following: <input type="checkbox"/> Metastatic Renal Cell Carcinoma <input type="checkbox"/> Metastatic Melanoma <input type="checkbox"/> HIV [in combination with highly active antiretroviral therapy (HAART)] <input type="checkbox"/> T-cell lymphoma <input type="checkbox"/> Colorectal Cancer <input type="checkbox"/> Non-Hodgkin Lymphoma <input type="checkbox"/> Acute Myelogenous Leukemia (AML) <input type="checkbox"/> Autologous Bone Marrow Transplantation (ABMT)
3. Is the patient's ECOG performance status greater than 1?
4. Are the patient's cardiac and pulmonary functions within normal limits as defined by thallium stress testing and pulmonary function testing?
5. Is Proleukin being administered through one of the following: the Home Health, Physician's Office or Outpatient Services?
6. Is Proleukin being administered to the patient through the Home Infusion Pharmacy under the Healthcare Professional's supervision experienced in the use of anticancer agents?
7. 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: _____
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<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>.