



**Rilutek**  
(riluzole)

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

**Please have the information below ready when calling in the authorization.**

|                    |                     |
|--------------------|---------------------|
| Member's Last Name | Member's First Name |
| VH ID number       | Date of Birth       |
| Prescriber's Name  | Contact Person      |
| Office phone       | Office Fax          |

|             |            |
|-------------|------------|
| Medication: | Diagnosis: |
|-------------|------------|

- 1. Is the patient diagnosed with Amyotrophic Lateral Sclerosis (ALS)?**
- 2. 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 provide all information requested on this form 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>.