



**Trisenox
(Arsenic Trioxide)**

**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?
2. Is the diagnosis or indication for the treatment of Acute Promyelocytic Leukemia (APL)?
3. Is the patient's APL characterized by the t(15;17) translocation or PML/RAR-alpha gene expression?
4. Is the patient refractory to (or have relapsed from) retinoid and anthracycline chemotherapy?
5. Are the patient's ECG and electrolytes (potassium, calcium, magnesium) within normal limits prior to the initiation of therapy?
6. Is Trisenox being administered through one of the following: the Home Health, Physician's Office or Outpatient services?
7. Is Trisenox being administered to the patient through the Home Infusion Pharmacy under the Healthcare Professional's supervision experienced in the management of patients with Acute Leukemia?
8. Are there any other comments, diagnoses, symptoms, and/or any other information 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 _____			