



**Vidaza  
(Azacitidine)**

**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	
<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
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1. Is the initial prescription written or recommended by an Oncologist/Hematologist?
2. Is the diagnosis or indication for the treatment of one of the following:
  - Myelodysplastic syndrome subtypes: refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, refractory with excess blasts in transformation, and chronic myelomonocytic leukemia
  - Refractory Acute Lymphocytic Leukemia
  - Refractory Acute Myelogenous Leukemia
3. Is Vidaza being administered through one of the following: the Home Health, Physician's Office or Outpatient services?
4. Is Vidaza being administered by the patient or a caregiver at home?
5. 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: \_\_\_\_\_

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>.