



**Acetazolamide  
(acetazolamide)**

**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:
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<b>1. Does the patient have a functioning transplanted kidney?</b>
<b>2. Does the patient have a creatinine clearance &gt; 80 ml/minute?</b>
<b>3. Does the patient have a creatinine clearance between 50-80 ml/minute? If no, continue to #4.</b>
<b>4. Does the patient have a creatinine clearance between 10-50 ml/minute?</b>
<b>5. Are there any other comments, diagnoses, symptoms, and/or any other information you feel is important to this review?</b>

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>.