



Anagrelide
(Anagrelide)

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 |
| SCAN ID number | Date of Birth |
| Prescriber's Name | Contact Person |
| Office phone | Office Fax |

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

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| 1. Is the patient diagnosed with essential thrombocythemia secondary to myeloproliferative disorders, to reduce the elevated platelet count and the risk of thrombosis and to ameliorate associated symptoms? |
| 2. Is the prescription being prescribed by an Oncologist/Hematologist? |
| 3. 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 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>.