



Carimune (Immune Globlin)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: 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, SCAN ID number, Date of Birth, Est. Start Date, Office Contact, For Specialty Medications Only: Shipping Address (if different from home address) [ ] Physician [ ] 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

This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

1. Does the patient have a diagnosis of primary immune deficiency disease?
2. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?
3. Will this medication be administered for any FDA-approved indication?
4. Is the medication supplied and administered by a Physician's office?
5. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels 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.