



**Engerix- B**  
(hepatitis B)

**Express Scripts**  
**Prior Authorization**  
**Phone 800-417-8164**

Member's Last Name	Member's First Name
SCAN ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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**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.**

<b>1. Is vaccine administered to a member who is at high or intermediate risk of contracting hepatitis B?</b>
<b>2. Is vaccine administered to a member who is at low risk of contracting hepatitis B?</b>
<b>3. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</b>

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>.