



Vidaza (Azacitidine)

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. 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:
a) Myelodysplastic syndrome subtypes: refractory anemia, refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, or chronic myelomonocytic leukemia
b) Refractory Acute Lymphocytic Leukemia
c) Refractory Acute Myelogenous Leukemia
3. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?
4. Is the medication supplied by a Physician's office?
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 \_\_\_\_\_