



Candidas
(Caspofungin)

Prior Authorization Form
Curascript
Fax (888) 773-7386

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------|----------------|
| 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) <input type="checkbox"/> Physician <input type="checkbox"/> 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 |
|-------------------------------------------|-------|-----------------|-----------|--------------|

- Is the diagnosis or indication for the treatment of one of the following: Empirical therapy for presumed fungal infections in febrile, neutropenic patients, Candidemia, Esophageal candidiasis, or invasive aspergillosis?**
- Has the diagnosis been confirmed by laboratory testing?**
- Is the prescription recommended or initially written by an Infectious Disease Specialist?**
- Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?**
- Is the medication supplied and administered by a Physician's office?**
- Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

| | | |
|------------------------------|------------------|-------------|
| Physician's Signature: _____ | NPI/DEA #: _____ | Date: _____ |
|------------------------------|------------------|-------------|

| | |
|-------------------------------------------------------------------|-----------------------------------------------|
| For Internal Use Only | |
| <input type="checkbox"/> Approved <input type="checkbox"/> 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>.