



**Ontak**  
(Denileukin Diftitox)

**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 |      |       |     |
| <b>For Specialty Medications Only:</b><br>Shipping Address (if different from home address)<br><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 |
|---|-------|-----------------|-----------|--------------|

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|--|
| 1. Is the diagnosis or indication for the treatment of patients with persistent or recurrent cutaneous T-cell lymphoma? If no continue to #3                           |
| 2. Does the patient's malignant cells express CD25 component of IL-2 receptor confirmed by laboratory testing?   |
| 3. Is the diagnosis or indication for one of the following:<br>a. Treatment of chronic lymphocytic leukemia refractory to fludarabine<br>b. Non-Hodgkin lymphoma       |
| 4. Is the prescription recommended or initially written by an Oncologist or Hematologist who is experienced in the use of antineoplastic therapy?                      |
| 5. Are the following laboratory tests performed prior to initiation of Ontak: CBC, blood chemistry panel, including liver and renal function and serum albumin levels? |
| 6. Is the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?  |
| 7. Is the place where medication will be administered equipped for cardiopulmonary resuscitation and where the patient is closely monitored?                           |
| 8. Is the medication supplied and administered by a Physician's office?  |
| 9. 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>.