



Velcade

Express Scripts  
 Prior Authorization  
 Phone 1-844-424-8886  
 Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: [medicarepartdparequests@express-scripts.com](mailto:medicarepartdparequests@express-scripts.com)

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:
-------------	------------

**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.**

**SECTION A**

Please answer the following questions

1.  Yes  No Is the initial prescription written or recommended by an Oncologist?
2.  Yes  No Is the diagnosis or indication for the treatment of Multiple Myeloma? *(If No, skip to question 7.)*
3.  Yes  No Is the patient initiating a cycle of therapy with Velcade in combination with melphalan and prednisone?
4.  Yes  No Is the patient's platelet count  $70 \times 10^9$ /liter or more and absolute neutrophil count (ANC)  $1.0 \times 10^9$ /liter or more?
5.  Yes  No Has the patient experienced nonhematological toxicities with the previous Velcade use?
6.  Yes  No Have non-hematological toxicities resolved to Grade 1 or baseline?
7.  Yes  No Is the diagnosis or indication for the treatment of Mantle Cell Lymphoma?
8.  Yes  No Does the patient have a documented history of at least one prior therapy for the current condition?
9.  Yes  No Is Velcade supplied by Retail, Home Infusion, Long Term Care or other pharmacies?

10. Is the medication supplied by a Physician's office?

Yes

No (Document how the medication is supplied):

---

**Please document the symptoms and/or any other information important to this review:**

---

---

---

---

---

---

**SECTION B** Physician Signature

---

PHYSICIAN SIGNATURE

---

DATE

**FAX COMPLETED FORM TO: 1-877-251-5896**

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.scanhealthplan.com>