PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Adagen (pegademase bovine)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

- ☐ Severe combined immunodeficiency disease (SCID)
- ☐ Other (Please Specify)

Q2. Please provide ICD code(s) for diagnosis.

Q3. How will Adagen be billed?

- ☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim and dispensed by pharmacy directly to member)
- ☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim, but shipped direct to provider to be administered to this specific member)
- ☐ MEDICAL claim (drug to be billed by PROVIDER as a MEDICAL benefit claim as an expense to the provider, and provider to supply drug to member)

Q4. If billing as a MEDICAL claim, what provider will be linked to the claim (i.e. who is the billing entity seeking reimbursement)? Provide Name and NPI

- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Adagen (pegademase bovine)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

Q5. Is the patient less than or equal to 18 years of age?

☐ Yes ☐ No

Q6. Does the patient require enzyme replacement therapy for adenosine deaminase (ADA) deficiency?

☐ Yes ☐ No

Q7. Has the patient failed a bone marrow transplantation?

☐ Yes ☐ No

Q8. Is the patient a suitable candidate for bone marrow transplantation?

☐ Yes ☐ No

Q9. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.