# Albenza (albendazole)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK:** HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTOR** (if different than prescriber)**:** | **OFFICE CONTACT PERSON:** |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES): | | | |

*Continued on next page*

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| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ YES (if yes, complete below) ☐ NO | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE)**:** | **DURATION OF THERAPY** (SPECIFY DATES)**:** | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ *Ancylostoma caninum* (eosinophilic enterocolitis)<br>☐ *Ancylostoma duodenale* or *Necator americanus* (hookworms)<br>☐ *Ascariasis* (intestinal roundworm):<br>☐ *Clonorchis sinensis* (Chinese liver fluke) or *Opisthorchis viverrini* (Southeast Asian liver fluke)<br>☐ Cutaneous larva migrans (dog and cat hookworm)<br>☐ Enterobiasis (pinworm)<br>☐ Giardiasis *(Giardia duodenalis)*<br>☐ Hydatid disease (*Echinococcus granulosis*, dog tapeworm)<br>☐ Microsporidiosis<br>☐ Neurocysticercosis (*Taenia solium*, pork tapeworm), parenchymal disease<br>☐ *Oesophagostomum bifurcum*<br>☐ Taeniasis<br>☐ Toxocariasis *Ocular larva migrans*<br>☐ Toxocariasis *Visceral larva migrans*<br>☐ Trichinellosis (*Trichinella spiralis*)<br>☐ Other diagnosis: _____ ICD-10 Code(s): | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Is patient going to be using drug in a clinical trial? ☐ Yes ☐ No**

**Microsporidiosis:**
**Is patient Immunocompetent with one of the below?**
**☐ Disseminated infection**
**☐ Intestinal (*Encephalitozoon intestinalis*) infection**
**☐ Ocular infection**

**Is patient Immunocompromised (eg, patients with HIV) with one of the below?**

**☐ Disseminated or intestinal infection (other than *Enterocytozoon bieneusi* or *Vittaforma corneae*):**

**☐ Ocular infection: Oral: 400 mg twice daily, in combination with topical fumagillin; continue until resolution of ocular symptoms and until CD4 count >200 cells/mm$^3$ for >6 months after initiation of antiretroviral therapy.**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____



**FAX THIS FORM TO:** 800-424-7640

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program Attn:CP-4201
P.O.Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909