

Pediatric Oncology Prior Authorization Request Form

REQUEST DATE:	TREATMENT START DATE:	Standard	□ Expedited
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I. MEMBER INFORMATION

First:	Last:	DOB:	□ Male □ Female
Height:	Weight:	BSA (m²):	<u>, I</u>
Diagnosis:	ICD-10:	Stage/Phase:	
Insurance:	Line of Business (e.g., Medicare):	Member ID:	
Is this member being treated with a Children's Oncology Group (COG)		(examp	ble: AALL1131)

II. OUTPATIENT DRUGS THAT WILL BE BILLED TO THE HEALTH PLAN New Retrospective Re-authorization *Note: Do not include drugs that will be study-supplied, free of charge or administered inpatient.*

#	Billing Code	Drug Name	Billing	Method
1			□ Buy & Bill	Pharmacy
2			□ Buy & Bill	Pharmacy
3			□ Buy & Bill	Pharmacy
4			□ Buy & Bill	Pharmacy
5			□ Buy & Bill	Pharmacy
6			□ Buy & Bill	Pharmacy
7			□ Buy & Bill	Pharmacy
8			□ Buy & Bill	Pharmacy

III. PROVIDER AND PLACE OF TREATMENT INFORMATION

Ordering Provider:	NPI #:	TIN #:			
	Phone:	Fax:			
Treating Provider: (if different)	NPI #:	TIN #:			
Place of Treatment: (if different)	NPI #:	TIN #:			
Has the member been receiving cancer treatments from the requesting treating provider? Yes No Unknown					
Is treating provider in-network? Ves No Unknown					
Requestor's Name:	Phone:	Fax:			

SUBMIT PROGRESS NOTES, CHEMO ORDERS, LABS, PATHOLOGY AND IMAGING RESULTS WITH REQUEST.

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