

Chemotherapy and Supportive Care Prior Authorization Request Form

REQUEST DATE: _____

TREATMENT START DATE: _____

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

Standard

Urgent - Mark as **Urgent**, if the request meets one of the definition/level of service listed below

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological function; or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- Based on this definition, I hereby submit this authorization as an urgent request

I. MEMBER INFORMATION

| | | | |
|------------|------------------------------------|------------------------|---|
| First: | Last: | DOB: | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Height: | Weight: | BSA (m ²): | |
| Diagnosis: | ICD-10: | Stage (0-4): | |
| Insurance: | Line of Business (e.g., Medicare): | Member ID: | |

II. ANTI-CANCER TREATMENT AND SUPPORTIVE DRUG REQUEST

| # | Billing Code | Drug Name | Route | Dose | Frequency & Schedule | Indication | Is the patient currently being treated with this regimen? (Y=Yes, N= No) | Request Brand Name | Billing Method (B = Buy & Bill or P = Pharmacy) | If applicable, Do you agree to opt-in to vial rounding? (Y=Yes, N= No) |
|---|--------------|-----------|-------|------|----------------------|------------|--|--------------------------------|---|--|
| Please list ALL components of the ENTIRE regimen, including oral and PA Exempt drugs | | | | | | | | | | |
| 1. | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Brand | <input type="checkbox"/> B <input type="checkbox"/> P | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2. | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Brand | <input type="checkbox"/> B <input type="checkbox"/> P | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3. | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Brand | <input type="checkbox"/> B <input type="checkbox"/> P | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 4. | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Brand | <input type="checkbox"/> B <input type="checkbox"/> P | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 5. | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Brand | <input type="checkbox"/> B <input type="checkbox"/> P | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 6. | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Brand | <input type="checkbox"/> B <input type="checkbox"/> P | <input type="checkbox"/> Y <input type="checkbox"/> N |

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 #: |
| Office Contact: | Phone: | Fax: |

IV. PREFERRED PRODUCTS

- a. **If applicable**, do you agree to substitution of a Reference product with its FDA-approved Biosimilar product when part of a mandatory Step-Therapy Program*? Yes No Unknown
- *Per CMS, mandatory changes to preferred products do **NOT** apply to **Medicare** patients if they have received the Non-Preferred product in the past 365 days.
- b. **If yes**, please list preferred Biosimilar product here: (JCode) _____ (Name) _____
- (For a list of Preferred Products, please see individual Step Therapy Policy, call OncoHealth at (877) 815-0819, or submit request via <https://support.oncohealth.us>)

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