SAS
SOLUCIONES ANALITICAS DE SALUD

Metro Office Park, Millennium Park Plaza 15, Street 2, Ste 540, Guaynabo, PR 00968
Phone: 877-815-0819 • Fax: 844-964-7707
www.oncohealth.us

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:	☐ Male ☐ 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.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
2.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
3.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
4.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
5.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
6.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ 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)

PRINT SAVE PDF