



Need to submit a request quickly? Visit our web portal at oneum.oncohealth.us

# Billing Drug Name Route Dose Schedule Indication Treated with Brand (B = Buy	ATE:	
□ 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, bas layperson's judgement; or □ Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, bas layperson's judgement; or □ Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological funcion in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the 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 ■ Last: ■ DOB: ■ Member ID: ■ DOB: ■ DOB: ■ DOB: ■ DOB:	GING RESULTS WITH REQUEST	
□ 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, bas layperson's judgement; or □ Could seriously jeopardize the life or health or safety of the member or others, due to the member's psychological function in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the health consequences without the care or treatment that is the subject of the request. I. MEMBER INFORMATION Last: DOB: First: Last: BSA (m²): Insurance: Line of Business (e.g., Medicare): Member ID: It is this member being treated with a Children's Oncology Group (COG) Protocol? No Yes: Enter COG # II. ANTI-CANCER TREATMENT AND SUPPORTIVE DRUG REQUEST Indication Is the patient currently being request. When the protocol of the service of the currently being Brand the service of the s	_	
Height: Weight: Stage (0-4): Diagnosis: ICD-10: Stage (0-4): Insurance: Line of Business (e.g., Medicare): Member ID: Is this member being treated with a Children's Oncology Group (COG) Protocol? No Yes: Enter COG # II. ANTI-CANCER TREATMENT AND SUPPORTIVE DRUG REQUEST Billing Code	ychological function; or	
Diagnosis: Insurance: Line of Business (e.g., Medicare): Member ID: Is this member being treated with a Children's Oncology Group (COG) Protocol?	DOB:	
Insurance: Line of Business (e.g., Medicare): Member ID: Is this member being treated with a Children's Oncology Group (COG) Protocol? No Yes: Enter COG # Hamiltonian Provider: No Yes Protocol? Yes Yes Enter COG Protocol? Yes Protocol.	SA (m ²):	
Is this member being treated with a Children's Oncology Group (COG) Protocol? No Yes: Enter COG #	Stage (0-4):	
Hard Part	Member ID:	
# Billing Code Drug Name Route Dose Frequency & Indication Currently being treated with this regimen? (Y=Yes, N=No) Please list ALL components of the ENTIRE regimen, including oral and PA Exempt drugs 1.	(Example: AALL1131)	
# Billing Code Drug Name Route Dose Frequency & Indication treated with this regimen? (Y=Yes, N=No) Please list ALL components of the ENTIRE regimen, including oral and PA Exempt drugs 1.		
1. Y N Brand B 2. Y N Brand B 3. Y N Brand B 4. Y N Brand B 5. Y N Brand B 6. Y N Brand B II. PROVIDER AND PLACE OF TREATMENT INFORMATION Ordering Provider: NPI #: TIN #: Fax: Phone: Fax: F	ind (B = Buy & Bill or to opt-in to v	gree o vial ng?
2. Y N Brand B 3. Y N Brand B 4. Y N Brand B 5. Y N Brand B 6. Y N Brand B II. PROVIDER AND PLACE OF TREATMENT INFORMATION Ordering Provider: NPI #: TIN #: Phone: Fax:	•	
3.	rand 🗆 B 🗆 P 🗀 Y 🗆 N] N
4.	rand 🗆 B 🗆 P 🗀 Y 🗆 N] N
5. Y N Brand B 6. Y N Brand B II. PROVIDER AND PLACE OF TREATMENT INFORMATION Ordering Provider: NPI #: TIN #: Phone: Fax:	rand 🗆 B 🗆 P 🗆 Y 🗆 N] N
6.	rand 🗆 B 🗆 P 🗀 Y 🗆 N] N
II. PROVIDER AND PLACE OF TREATMENT INFORMATION Ordering Provider: NPI #: Phone: Fax:	rand B P Y N] N
Ordering Provider: NPI #: Phone: Fax:	rand 🗆 B 🗆 P 🗀 Y 🗆 N] N
Phone: Fax:	TIN #·	
Treating Provider: (if different) NPI #: TIN #:		
	 IN #:	
Place of Treatment: (if different) NPI #: TIN #:	IN #:	
Office Contact: Phone: Fax:	ax:	
V. PREFERRED PRODUCTS a. If applicable, do you agree to substitution of a Reference product with its FDA-approved Biosimilar product when part Therapy Program*? *Per CMS, mandatory changes to preferred products do NOT apply to Medicare patients if they have received the Non-Preferred p b. If yes, please list preferred Biosimilar product here: (JCode) (For a list of Preferred Products, please see individual Step Therapy Policy, call OncoHealth at (888) 916-2616, or submit request via	Non-Preferred product in the past 365 days.	ays.

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