sunshine health™

**MEDICATION PRIOR AUTHORIZATION REQUEST FORM**
**FAX this completed form to 1-833-546-1507**
**OR Mail request to: Pharmacy Services Prior Authorization Dept.**
**5 River Park Place East, Suite 210 | Fresno, CA 93720**
Call 1-866-399-0928 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.
**ORAL ONCOLOGY AGENTS (Maximum Approval = One Year)**
**Note: Form must be completed in full. An incomplete form may be returned.**

Reset Form | Print Form

**Recipient's Medicaid ID#**

**Date of Birth (MM/DD/YYYY)** ☐☐ / ☐☐ / ☐☐☐☐

**Recipient's Full Name**

**Prescriber's Full Name**

**Prescriber's NPI**

**Prescriber Phone Number** ☐☐☐ - ☐☐☐ - ☐☐☐☐

**Prescriber Fax Number** ☐☐☐ - ☐☐☐ - ☐☐☐☐

**Provider Specialty:** _____

**Medication Request:** ☐ **New** ☐ **Continuation** **Ht**: _____ in _____ cm **Wt**: _____ lb _____ kg **BSA:** _____

**1. Medication Requested:**

| Medication | Strength | Directions | # of Cycles | Quantity/Month |
|---|---|---|---|---|
| | | | | |
| | | | | |

**2. Diagnosis**

☐ Breast Cancer ☐ Renal Cancer ☐ Prostate Cancer ☐ Lung Cancer ☐ Ovarian Cancer
☐ Leukemia ☐ Other Diagnosis: _____

**3. Previous Medication Trials**

| Medication | Strength | Directions | Start/End Dates | Maximum Dose (Per Day) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**4. List all other medications the patient is taking concurrently with the antineoplastic:**

| Medication | Strength | Directions | # of Cycles |
|---|---|---|---|
| | | | |
| | | | |

**Prescriber's Signature:** _____ **Date:** _____

**REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.**



**For AHCA Use Only**

**DATE:** _____ **NOTIFIED:** _____

**APPROVED:** _____ **START DATE:** _____ **EXPIRATION DATE:** _____

**DENIED:** _____ **REASON:** _____