



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.

Recipient's Medicaid ID#

Grid for Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Provider Specialty: _____

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

1. Medication Requested:

Table with 5 columns: 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

Table with 5 columns: Medication, Strength, Directions, Start/End Dates, Maximum Dose (Per Day)

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

Table with 4 columns: 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.

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For AHCA Use Only. Fields: DATE, NOTIFIED, APPROVED, START DATE, EXPIRATION DATE, DENIED, REASON.