

ONCOLOGY AGENTS, ORAL PRIOR AUTHORIZATION FORM

- Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please **include all requested documentation** (chart notes, laboratory data, etc.).
- To review the prior authorization guidelines for Oncology Agents, Oral, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Oncology Agents, Oral** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____	
<input type="checkbox"/> Renewal request	PA#: _____			
Name of office contact: _____			Specialty: _____	
Contact's phone number: _____			State license #: _____	
Facility contact/phone: _____			NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION			Street address: _____	
Recipient Name: _____			Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____	

CLINICAL INFORMATION

Medication requested: (SP) indicates a drug is part of the Specialty Pharmacy Drug Program. See question 3. **(NP) = non-preferred agent**
(**Temozolomide manufactured by Sandoz is preferred. Temozolomide from all other manufacturers is non-preferred.)

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|--|--|--|---|--|
| <input type="checkbox"/> Afinitor (SP) | <input type="checkbox"/> Erivedge (SP) | <input type="checkbox"/> Lenvima | <input type="checkbox"/> Tafinlar (SP) | <input type="checkbox"/> Xalkori (SP) |
| <input type="checkbox"/> Afinitor Disperz (SP) | <input type="checkbox"/> Farydak (SP) | <input type="checkbox"/> Lonsurf | <input type="checkbox"/> Tagrisso | <input type="checkbox"/> Xeloda (SP) |
| <input type="checkbox"/> Alecensa (SP) | <input type="checkbox"/> Gilotrif | <input type="checkbox"/> Lynparza | <input type="checkbox"/> Tarceva (SP) | <input type="checkbox"/> Xtandi (SP) |
| <input type="checkbox"/> Bicalutamide | <input type="checkbox"/> Gleevec (SP) | <input type="checkbox"/> Mekinist (SP) | <input type="checkbox"/> Tassigna (SP) | <input type="checkbox"/> Zelboraf (SP) |
| <input type="checkbox"/> Bosulif (SP) | <input type="checkbox"/> Ibrance (SP) | <input type="checkbox"/> Nexavar (SP) | <input type="checkbox"/> Temodar (SP) | <input type="checkbox"/> Zolanza (SP) |
| <input type="checkbox"/> capecitabine (NP) (SP) | <input type="checkbox"/> Iclusig (SP) | <input type="checkbox"/> Ninlaro | <input type="checkbox"/> temozolomide (Sandoz mfr)** (SP) | <input type="checkbox"/> Zydelig (SP) |
| <input type="checkbox"/> Caprelsa | <input type="checkbox"/> Imbruvica | <input type="checkbox"/> Odomzo (SP) | <input type="checkbox"/> temozolomide (NP) (SP) | <input type="checkbox"/> Zykadia (SP) |
| <input type="checkbox"/> Casodex (NP) | <input type="checkbox"/> Inlyta (SP) | <input type="checkbox"/> Sprycel (SP) | <input type="checkbox"/> Tykerb (SP) | <input type="checkbox"/> Zytiga (SP) |
| <input type="checkbox"/> Cometriq | <input type="checkbox"/> Iressa | <input type="checkbox"/> Stivarga (SP) | <input type="checkbox"/> Votrient (SP) | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Cotellic (SP) | <input type="checkbox"/> Jakafi (SP) | <input type="checkbox"/> Sutent (SP) | | |

Strength: _____	Directions: _____	Quantity: _____	Refills: _____
1. What is the Recipient's diagnosis?		<i>Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.</i>	
2. What is the corresponding diagnosis code?			
3. Drugs that are marked with (SP) in the chart above are part of the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used? (Refer to the Department's SPDP website for more information: http://www.dhs.pa.gov/provider/pharmacyservices/thespecialtypharmacydrugprogram/index.htm .)		<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy	
4. For non-preferred requests only [drugs marked above with (NP)] , does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred alternative agent (i.e., the preferred therapeutically equivalent (AB-rated) brand or generic product)?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen tried and treatment outcomes</i> <input type="checkbox"/> No	
5. For renewal requests only , since the requested medication was started, has the Recipient experienced a positive clinical response to therapy?		<input type="checkbox"/> Yes – <i>submit documentation of Recipient's response to therapy</i> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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