ONCOLOGY AGENTS, ORAL PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PerformRx[SM] Next Generation Pharmacy Benefits

Fax to PerformRx[SM] at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		Facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:		Specialty:
State license #:	NPI:	MA Provider ID#:
Street address:	Suite #:	City/state/zip:
Phone:		Fax:

PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

CLINICAL INFORMATION

Medication requested: (NP) = non-preferred agent

☐ Afinitor	☐ Caprelsa	☐ Gleevec (NP)	☐ Kisqali Femara	☐ Odomzo	☐ Sprycel	☐ Tibsovo	☐ Xtandi
☐ Afinitor Disperz	☐ Casodex (NP)	☐ Ibrance	☐ Lenvima	☐ Rubraca	☐ Stivarga	☐ Tykerb	☐ Yonsa (NP)
☐ Alecensa	☐ Cometriq	☐ Iclusig	☐ Lorbrena	☐ Mekinist	☐ Sutent	☐ Venclexta	☐ Zejula
☐ Alunbrig	☐ Copiktra	☐ Idhifa	☐ Lonsurf	☐ Mektovi (NP)	☐ Tafinlar	☐ Verzenio	☐ Zelboraf
☐ bicalutamide	☐ Cotellic	☐ imatinib (NP)	☐ Lynparza	☐ Nerlynx	☐ Tagrisso	☐ Vitrakvi	☐ Zolinza
☐ Bosulif	☐ Daurismo	☐ Imbruvica	☐ Mekinist	☐ Nexavar	☐ Talzenna	☐ Vizimpro	☐ Zydelig
☐ Braftovi (NP)	☐ Erivedge	☐ Inlyta	☐ Mektovi (NP)	☐ Ninlaro	☐ Tarceva	☐ Votrient	☐ Zykadia
☐ Cabometyx	☐ Erleada	☐ Iressa	☐ Nerlynx	☐ Odomzo	☐ Tasigna	☐ Xalkori	☐ Zytiga (NP)
☐ Calquence	☐ Farydak	☐ Jakafi	☐ Nexavar	☐ Rubraca	☐ Temodar (NP)	☐ Xeloda (NP)	☐ other:________
☐ capecitabine	☐ Gilotrif	☐ Kisqali	☐ Ninlaro	☐ Rydapt	☐ temozolomide	☐ Xospata	

Strength & dosage form:	Quantity:	Refills:
Directions:		

Question	Response
1. What is the patient's diagnosis?	Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.
2. What is the corresponding diagnosis code?	
3. Is the medication being prescribed by, or in consultation with, a hematologist or oncologist?	☐ Yes ☐ No
4. For <u>non-preferred requests only [drugs marked above with (NP)]</u>, does the patient 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), or has the patient taken the non-preferred medication in the past 90 days?	☐ Yes – *Submit all supporting documentation of drug regimen tried and treatment outcomes.* ☐ No
5. For renewal requests only, since the requested medication was started, has the patient experienced a positive clinical response to therapy?	☐ Yes – *Submit documentation of patient's response to therapy.* ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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