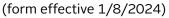
## **ONCOLOGY AGENTS, ORAL PRIOR AUTHORIZATION FORM**







Fax to PerformRx<sup>™</sup> at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHO	<b>RIZATION REQUEST</b>	INFORMATI	ON									
□ New request □	request				Name of office contact:							
Contact's phone number:				Facility contact/phone:								
PATIENT INFO	RMATION											
Patient name:				Patient ID #:					DOB	i:		
Street address:				Apt. #: City/state/zip:				e/zip:				
PRESCRIBER INFORMATION												
Prescriber name:						Specialty:						
State license #:	ate 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:												
Strength & dosage form:						Quantity:				Refills:		
Directions:												
What is the patient's diagnosis?     What is the corresponding diagnosis code?										ntation confirming diagnosis, such as chart s, biopsy results, etc.		
3. Is the medication being prescribed by, or in consultation with, a hematologist or oncologist?										□ Yes		
4. For requests for a non-preferred medication: Does the patient have a history of trial and failure, contraindication, or intolerance to the preferred medications in this class that are FDA-approved or medically accepted for the treatment of the patient's diagnosis, or has the patient taken the non-preferred medication in the past 90 days? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.										docu	– Submit all supporting umentation of drug regimen d and treatment outcomes.	
5. For renewal requests only, since the requested medication was started, has the patient experienced a positive clinical response to therapy?										<ul> <li>Yes – Submit documentation of patient's response to therapy.</li> <li>No</li> </ul>		
PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION												
Prescriber signature:										Date	;; ;;	

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.