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### Chemotherapy and Supportive Care Prior Authorization Request Form

REQUEST DATE: \_\_\_\_\_

TREATMENT START DATE: \_\_\_\_\_

**PLEASE SUBMIT PROGRESS NOTES, COMPLETE CHEMO ORDERS, LABS, PATHOLOGY AND IMAGING RESULTS WITH REQUEST**

- Standard  
 Urgent

**I. MEMBER INFORMATION**

First:	Last:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Height:	Weight:	BSA (m <sup>2</sup> ):	
Diagnosis:	ICD-10:	Stage (0-4):	
Insurance:	Line of Business (e.g., Medicare):	Member ID:	

**II. ANTI-CANCER TREATMENT AND SUPPORTIVE DRUG REQUEST**

#	Billing Code	Drug Name	Route	Dose	Frequency & Schedule	Indication	Is the patient currently being treated with this regimen? (Y=Yes, N= No)	Request Brand Name	Billing Method (B = Buy & Bill or P = Pharmacy)	If applicable, Do you agree to opt-in to vial rounding? (Y=Yes, N= No)
<b>Please list ALL components of the ENTIRE regimen, including oral and PA Exempt drugs</b>										
1.							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Brand	<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N
2.							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Brand	<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N
3.							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Brand	<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N
4.							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Brand	<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N
5.							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Brand	<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N
6.							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Brand	<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N

**III. PROVIDER AND PLACE OF TREATMENT INFORMATION**

Ordering Provider:	NPI #:	TIN #:
	Phone:	Fax:
Treating Provider: (if different)	NPI #:	TIN #:
Place of Treatment: (if different)	NPI #:	TIN #:
Office Contact:	Phone:	Fax:

**IV. PREFERRED PRODUCTS**

- a. **If applicable**, do you agree to substitution of a Reference product with its FDA-approved Biosimilar product when part of a mandatory Step-Therapy Program\*?  Yes  No  Unknown
- \*Per CMS, mandatory changes to preferred products do **NOT** apply to **Medicare** patients if they have received the Non-Preferred product in the past 365 days.
- b. **If yes**, please list preferred Biosimilar product here: (JCode) \_\_\_\_\_ (Name) \_\_\_\_\_
- (For a list of Preferred Products, please see individual Step Therapy Policy, call OncoHealth at (888) 916-2616, or submit request via OH Web Portal at: <https://oneum.oncohealth.us>)