pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ONCOLOGY AGENTS, ORAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Oncology Agents, Oral** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
Facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: (See question 3 below regarding agents in the Specialty Pharmacy Drug Program.) ***(NP) = non-preferred agent***

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

☐other: _____

Strength & dosage form:	Directions:	Quantity:	Refills:

1. What is the beneficiary'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. Most oral oncology agents are included in the Department's Specialty Pharmacy Drug Program (SPDP). Which 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.)	☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy
5. ***For non-preferred requests only [drugs marked above with (NP)]***, does the beneficiary 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 beneficiary taken the non-preferred medication in the past 90 days?	☐Yes – *Submit all supporting documentation of drug regimen tried and treatment outcomes.* ☐No
6. ***For renewal requests only***, since the requested medication was started, has the beneficiary experienced a positive clinical response to therapy?	☐Yes – *Submit documentation of beneficiary's response to therapy.* ☐No

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

Prescriber Signature:	**Date:**