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, BREAST CANCER 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 Breast Cancer Oncology Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Oncology Agents, Breast Cancer** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
☐New request ☐Renewal request	☐Additional info PA#:_______________	# of pages in request: _________	Prescriber name:	
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

Non-preferred medication requested:	☐Arimidex tablet ☐Aromasin tablet	☐Fareston tablet ☐Femara tablet	☐Soltamox solution
Strength:	Directions:	Quantity:	Refills:

1. What is the Recipient's diagnosis?	*Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.*
2. What is the corresponding diagnosis code?	
For Fareston and Soltamox requests, go to question 3. For all other non-preferred requests, go to question 4.	
3. ***For Fareston and Soltamox requests only,*** does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred alternative agent, **tamoxifen tablet**?	☐Yes – *submit all supporting documentation of tamoxifen regimen tried and treatment outcomes* ☐No
4. ***For all other requests***, does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Breast Cancer Oncology Agents? *Check all that apply.* ☐anastrazole tablet ☐letrozole tablet ☐exemestane tablet	☐Yes – *submit all supporting documentation of preferred drug regimen tried and treatment outcomes* ☐No

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

Prescriber Signature:	**Date:**

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