

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 <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
Facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis:		<i>Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.</i>	
Diagnosis code:			

INITIAL requests

Has the beneficiary been taking the requested medication in the past 90 days?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No
<u>For requests for a non-preferred medication:</u> Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred medications in this class that are FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.	<input type="checkbox"/> Yes – <i>Submit all supporting documentation of drug regimen tried and treatment outcomes.</i> <input type="checkbox"/> No

RENEWAL requests

Since the requested medication was started, has the beneficiary experienced a positive clinical response to therapy?	<input type="checkbox"/> Yes – <i>Submit documentation of beneficiary's response to therapy.</i> <input type="checkbox"/> No
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PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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