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

☐New request ☐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:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis:		*Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.*	
Diagnosis code:			
SPECIALTY PHARMACY DRUG PROGRAM: Most drugs in the Oncology Agents, Oral class are included in the DHS Specialty Pharmacy Drug Program and are available from DHS's specialty pharmacy. Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Specialty-Pharmacy-Program.aspx for more information about the Specialty Pharmacy Drug Program.		DHS specialty pharmacy: Chartwell Pennsylvania, LP Oakdale, PA Phone: 833-710-0211 Fax: 412-920-1869 www.chartwellpa.com	

INITIAL requests	
Has the beneficiary been taking the requested medication in the past 90 days?	☐Yes – *Submit documentation.* ☐No
For requests for a non-preferred medication: 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.*	☐Yes – *Submit all supporting documentation of drug regimen tried and treatment outcomes.* ☐No

RENEWAL requests	
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: