HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

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:		Suite #:	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:			
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 866-240-3712

Prescriber Signature:	**Date:**