

**ONCOLOGY AGENTS, ORAL  
PRIOR AUTHORIZATION FORM**  
(form effective 1/8/2024)



**Keystone First**  
Community HealthChoices

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages:	Name of office contact:
Contact's phone number:		Facility contact/phone:	

PATIENT INFORMATION			
Patient name:	Patient ID #:	DOB:	
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION			
Prescriber name:	Specialty:		
State license #:	NPI:	MA Provider ID#:	
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION):	
Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

CLINICAL INFORMATION	
<b>Medication requested:</b>	
Strength & dosage form:	Quantity: Refills:
Directions:	
1. What is the patient'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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. For <b>requests for a non-preferred medication</b> : Does the patient have a history of trial and failure, contraindication, or intolerance to the preferred medications in this class that are FDA-approved or medically accepted for the treatment of the patient's diagnosis, or has the patient taken the non-preferred medication in the past 90 days? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> 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
5. For renewal requests only, since the requested medication was started, has the patient experienced a positive clinical response to therapy?	<input type="checkbox"/> Yes – <i>Submit documentation of patient's response to therapy.</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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