SELF - ADMINISTERED ONCOLOGY
POLICY X.124
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit https://www.nebraskablue.com. *Start saving time today by filling out this prior authorization form electronically.* Visit https://medicalpolicy.nebraskablue.com to begin using this free service.

What is the priority level of this request?

☐ Standard Review

☐ Expedited/Urgent review – waiting for a standard review could cause harm to patient

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Patient First Name:	Patient Last Name:	Middle Initial:	Date of Birth (MM/DD/YY):
Patient Address:	City, State, Zip Code:		Member ID Number:

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI #:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip Code:	Phone #:		Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

1. Is the patient currently treated with the requested medication?..... ☐ Yes ☐ No

If yes, is the patient at risk if they change therapy?..... ☐ Yes ☐ No

2. Please provide the following: Patient's Weight: _____ (kg). Patient's Height: _____ (cm).

3. Does the patient have an FDA-approved indication for treatment with the requested agent?..... ☐ Yes ☐ No

4. Does therapy with the requested agent require a specific genetic/diagnostic test for the requested indication (e.g., BRAFmutation, mutation, HER2 positive)?..... ☐ Yes ☐ No

If yes, has the patient completed the appropriate FDA approved genetic/diagnostic testing and results indicate therapy with the requested drug is appropriate?..... ☐ Yes ☐ No

5. Is the requested agent approved for use as the first line agent for the requested indication as supported by standard of care and guidelines (NCCN Compendium level of evidence or 2A)?..... ☐ Yes ☐ No

If no, has the patient tried and had an inadequate response to the first line agent(s) for the requested indication?..... ☐ Yes ☐ No

If no, does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent(s) for the the requested indication?..... ☐ Yes ☐ No

Requests for brand name products that have a generic equivalent:

6. Has the patient tried the available generic product for the requested indication?..... ☐ Yes ☐ No

If no, does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to the generic product?.. ☐ Yes ☐ No

If yes, please explain: _____

_____

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