Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Oral Oncology Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

- ❑ The recipient has a diagnosis that is indicated in the FDA approved package insert or listed in nationally recognized compendia, for the determination of medically accepted indications.
- ❑ The oral oncology medication is not indicated as a first line agent, either in the FDA approved package insert or nationally recognized compendia. Documentation of previous therapies tried and failed is provided.
- ❑ The medication is prescribed by or in consultation with an oncologist or hematologist.
- ❑ The recipient does not have any contraindications to the requested oral oncology medication.
- ❑ The requested quantity and dosing regimen falls within the manufacturer's published dosing guidelines or nationally recognized compendia and is appropriate for the recipient's age.
- ❑ The medication will be used in combination with other chemotherapeutic or adjuvant agents according to the FDA approved prescribing information.
- ❑ An FDA-approved companion diagnostic test for the requested agent was completed and documentation to confirm the diagnosis is provided.

  The name or code of the diagnostic test performed to confirm the diagnosis is: _____.
- ❑ A test with adequate ability to confirm a disease mutation was completed and documentation to confirm the diagnosis is provided.

  The name or code of the diagnostic test performed to confirm the diagnosis is: _____.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.