

**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>.

<input type="checkbox"/> New request	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes – Submit documentation. <input type="checkbox"/> No
<b><i>For requests for a non-preferred medication:</i></b> 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 <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 – Submit all supporting documentation of drug regimen tried and treatment outcomes. <input type="checkbox"/> No

**RENEWAL requests**

Since the requested medication was started, has the beneficiary experienced a positive clinical response to therapy?	<input type="checkbox"/> Yes – Submit documentation of beneficiary's response to therapy. <input type="checkbox"/> No
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**PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO 866-240-3712**

Prescriber Signature:	Date:
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