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

AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ 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: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

CLINICAL INFORMATION

Medication requested:		
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?		☐ Yes ☐ No
4. For **requests for a non-preferred medication**: 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 **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
5. For renewal requests only, since the requested medication was started, has the patient experienced a positive clinical response to therapy?		☐ Yes – *Submit documentation of patient's response to therapy.* ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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