PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Odomzo

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please provide ICD code(s) for diagnosis

Q2. For what diagnosis is this drug being prescribed (pick one)? *

- ☐ Basal cell carcinoma, locally advanced
- ☐ Other

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 2A or higher recommendation per NCCN compendia or guidelines.

Q4. Is prescribing physician a hematology or oncology specialist?

☐ Yes ☐ No

Q5. If locally advanced basal cell carcinoma, has the patient had a recurrence after surgery or is not a candidate for surgery?

☐ Yes ☐ No

Q6. If locally advanced basal cell carcinoma, has the patient had a recurrence after radiation or is the patient not a candidate for radiation?

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Odomzo

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Yes	☐ No
Q7. Additional Comments	

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.