PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Provenge

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. What diagnosis is this drug being prescribed for (pick one)?

☐ Metastatic prostate cancer with radiologic evidence of metastatic disease in the lymph nodes and/or bone
☐ Metastatic prostate cancer with radiologic evidence of visceral metastases (to liver, lung or brain)
☐ Metastatic prostate cancer with pathologic bone fractures
☐ Metastatic prostate cancer with spinal cord compression
☐ Other

Q2. Please provide ICD diagnosis code for above condition.

Q3. Is the prescribing physician an Oncologist or Hematologist?

☐ Yes ☐ No

Q4. Does the patient have hormone refractory (castrate resistant or androgen-independent) disease?

☐ Yes ☐ No

Q5. Is the patient's testosterone level <50ng/mL?

☐ Yes ☐ No

Q6. Please provide the patient's most recent testosterone level with draw date.

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Provenge

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:**

Q7. Does the patient have asymptomatic or minimally symptomatic disease?

☐ Yes ☐ No

Q8. Does the patient have a life expectancy of greater than 6 months?

☐ Yes ☐ No

Q9. Does the patient have an ECOG performance status of 0-1?

☐ Yes ☐ No

Q10. Does the patient have a Karnofsky score of 80-100?

☐ Yes ☐ No

Q11. Is the patient currently using chemotherapy or immunosuppressive therapy?

☐ Yes ☐ No

Q12. 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.

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Provenge

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:**

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document