

PRIOR AUTHORIZATION REQUEST FORM EOC ID:

Halaven

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 Physici	an:
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	e (if applicable):
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that nuestions and sign.	nay support approval. Please answer the
Q1. What diagnosis is this drug being prescribed for (pick	cone)?	
☐ Metastatic breast cancer		
Unresectable or metastatic liposarcoma		
☐ Other		
Q2. Please provide ICD codes for diagnosis		
Q3. If you selected "other" in question 1, please provide of higher recommendation per NCCN compendia or guideling		e is consistent with a category 2A or
Q4. Please indicate location of administration.		
☐ Home		
Long Term Care (LTC) facility		
Physician office (drug from office stock - buy and bill)		
☐ Physician office (drug from pharmacy with a prescript	ion)	
Q5. If for metastatic breast cancer, has the patient previo a taxane based and an anthracycline based treatment?	usly been treated with	at least 2 systemic therapies, including



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		Prescriber Name:	
Patient Name:		Supervising Physician:	
Yes	□ No		
Q6. If for unresectable or containing regimen?	metastatic liposarcoma, has the	patient previously been treatment with an anthracy	cline-
☐ Yes	□ No		
Q7. Does the patient hav	e any contraindication(s) for taxar	e or anthracycline based therapies?	
Yes	□ No		
Q8. What are the conti	raindications?		
Q9. Is the prescribing phy	ysician an Oncologist?		
Yes	□ No		
Q10. Additional Commen	nts		
Presc	riber 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.



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