

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Jevtana

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. For what diagnosis is this being prescribed (pick one)?		
Hormone refractory metastatic prostate cancer	Other	
Q2. If you selected "other" in question 1, please provide documentation that use is consistent with a category 1 recommendation per NCCN compendia or guidelines.		
Q3. Please provide the ICD diagnosis code for the above condition.		
Q4. Is the patient a new start to therapy?		
☐ Yes	No	
Q5. Is this being prescribed by a hematologist or oncologist?		
☐ Yes	No	
Q6. Is the patient on concurrent prednisone?		
☐ Yes	No	



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Patient Name:	Supervising Physician:	
Q7. Has the patient previously been treated with a docetaxel-containing treatment regimen?		
☐ Yes	No	
Q8. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement? Pharmacy Individual prescriber Provider or specialty group Facility Other (please specify)		
Q9. Provide name and NPI of the billing entity		
Q10. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?		
Medical	Pharmacy	
Q11. 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 a SWHP pharmacist
or medical director at 1-800-728-7947 regarding the case to have an opportun	ity to help impact the decision on a request before coverage
has been decided.	



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