



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Kadcyla

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. Has the patient received prior therapy for metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Has the patient developed disease recurrence during or within six months of completing adjuvant therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement? <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual prescriber <input type="checkbox"/> Provider or specialty group <input type="checkbox"/> Facility <input type="checkbox"/> Other (please specify)	
Q10. Provide name and NPI of the billing entity	
Q11. 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)? <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy	
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



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Prescriber Name:

Supervising Physician:

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 opportunity to help impact the decision on a request before coverage has been decided.

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