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 ☐ Other
Q2. Please provide ICD diagnosis code for above condition.
Q3. What is the quantity and days supply requested?
Q4. Is the patient a new start to therapy? ☐ Yes ☐ No
Q5. Does the patient have castrate resistant disease? ☐ Yes ☐ No
Q6. Does the patient have visceral metastases? ☐ Yes ☐ No
Q7. Does the patient have a life expectancy of greater than 6 months?

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☐ Yes ☐ No

Q8. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0-1?

☐ Yes ☐ No

Q9. Did the patient have disease progression while receiving Provenge?

☐ Yes
☐ No
☐ N/A - patient has not received Provenge before

Q10. 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)

Q11. Provide name and NPI of the billing entity

Q12. 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

Q13. Additional Comments:

Prescriber Signature

Date

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