



# PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

## Valchlor (mechlorethamine)

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member/Subscriber Number:	<b>Supervising Physician:</b>	
Date of Birth:	Fax:	Phone:
Group Number:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
	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. Please provide ICD code(s) for diagnosis.
Q2. Is the patient a new start to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q3. For what diagnosis is this drug being prescribed? <input type="checkbox"/> T-Cell Lymphoma - Mycosis Fungoides type <input type="checkbox"/> Other (please specify)
Q4. Does the patient have failure of adequate trial of or intolerance to one of the following? <input type="checkbox"/> Topical corticosteroids <input type="checkbox"/> Targretin 1% gel <input type="checkbox"/> Other (please specify) <input type="checkbox"/> None of the above
Q5. What is the patient's stage? <input type="checkbox"/> Stage I mycosis fungoides <input type="checkbox"/> Stage II mycosis fungoides <input type="checkbox"/> Stage III mycosis fungoides



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Patient Name: Prescriber Name: Supervising Physician:

Stage IV mycosis fungoides
Stage IV Sezary Syndrome
Q6. 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 opportunity to help impact the decision on a request before coverage has been decided.

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