

Date of Request (MM/DD/YYYY): ____/____/____ Time: ____ AM / PM

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PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of a drug on our prior authorization list. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information: Due to privacy regulations we will not be able to respond via fax with outcome of our review unless all asterisked (*) items on this form are completed.

* Patient Name:	* Plan ID#:	* Date of Birth:
Patient Height: ____ ft ____ in	Weight: ____ lbs	Patient Phone Number:
☐ Allergies: ☐ NKA		

B. Provider Information:

* Provider Name:	Specialty:	DEA or TIN #:	
Office Contact Person:	Office Phone:	Office Fax:	
Backline:			
*Is your fax machine kept in a secure location? ☐ Yes ☐ No		*May we fax our response to your office? ☐ Yes ☐ No	
Office Street Address:	City:	State:	Zip:

C. Treatment Information:

Type of Treatment: ☐ Initial ☐ Continuation of Treatment ☐ Subsequent			
Site of Administration: ☐ Provider's Office ☐ Self-Administered ☐ Outpatient (Center Name) ☐ Other:			
Primary Diagnosis ICD-9	Secondary Diagnosis ICD-9	Treatment Start Date:	Est Duration of Therapy # of Months _____ OR # of Cycles _____
ECOG/Performance Status (circle one): 0 1 2 3 4 5		Clinical Staging: ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Intent to Treat: ☐ Adjuvant ☐ Curative ☐ Recurrent/Metastatic/Palliative			
Clinical Trial: ☐ Yes ☐ No If Yes, Clinical Trail Name:			Continuous Infusions IV Pump Required? ☐ Yes ☐ No
Values: Her2 Overexpressed: ☐ Yes ☐ No EGFR: ☐ Positive ☐ Negative ER: ☐ Positive ☐ Negative PR: ☐ Positive ☐ Negative K-RAS Wild Type: ☐ Yes ☐ No ☐ Testing not applicable for request			

Continued on next page

J Code	Drug Name	Dose	Directions for Use	Buy and Bill	Pharmacy Replacement	Patient Acquired/ Physician Administered	Self-Administered Injectable / Oral
Chemotherapy (pre-meds and antiemetics)							
Growth Factors: ESA – Must provide recent HgB/Hct Myeloid Growth Factors: Must provide CBC documentation							
Other Medications:							

Authorized Medical Signature:	Phone Number:
Delivery Address: same as ☐ Patient, same as ☐ Physician, ☐ Other:	Date Needed:

When Completed Return To: ProCare PBM Clinical Division

Phone# 866-965-3784

Fax # 866-999-7736