REQUEST FOR PRIOR AUTHORIZATION
ONCOLOGY

Prescribing Physician:

Name (First, Last)	
Physician specialty	
Phone #	**Fax #**
Facility Name	**Facility Phone #**
Name and title of person completing form (please print)	

Administration Type:
□ Self-administered
□ Physician office
□ Hospital
□ Home Health Care □ Infusion Center

Fulfillment Type:
□ Buy and Bill
□ White Bag – medication received directly from a Specialty Pharmacy
□ Brown Bag – medication received from a patient

Patient:

Name (First, Last)	
ID #	
Phone #	**Client**
Birth Date	**Sex** M ☐ F ☐

Clinical Information:

Diagnosis:

Relevant Information Relating to Diagnosis:

Please submit chart notes and labs with the request.

CPT Codes associated with administration:

Days in Cycle:	**Number of Cycles:**

Chemotherapy Regimen

Name of medication	J-Code	Dose	Route	Duration	Frequency

Premedication and other Supportive Medications

Name of medication	J-Code	Dose	Route	Duration	Frequency

Physician's Signature_____**Date** ___/___/_____

Supportive documentation such as chart notes and laboratory findings must be submitted for the request to be reviewed.

(For SGRX use only)

Fax Request to: SGRX @ 313-264-0985

Date faxed: ___/___/___
Date received: ___/___/___
Date completed: ___/___/___

Decision (all authorizations are pending valid eligibility)