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 (at birth) ☐ 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)

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