CONTAINS CONFIDENTIAL PATIENT INFORMATION

Select Oncology

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	2. Physician information
Patient name: _	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx:_____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: CHECK ALL BOXES THAT APPLY

Note: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA-approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the prior authorization request: copies of medical records (i.e., diagnostic evaluations and recent chart notes); location of treatment (provider office, facility, home health, etc.); if medication requested is not an oral agent, the original prescription; and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.

Provider specialty: _____

Patient information: Height:_____(in)_____ (cm) Weight:_____ (lb)_____ (kg) BSA:_____

Diagnosis: _____

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Medication requested: ☐ New ☐ Continuation

Medication	Strength	Dosage instructions	# of cycles	Quantity	Days supply

Previous treatment trials:

Medication	Strength	Dosage instructions	# of cycles	Quantity	Days supply

Attach copies of the following:

☐ Medical records (i.e., diagnostic evaluations and recent chart notes)

☐ Original prescription

☐ Recent related laboratory results

Please indicate setting in which medication is to be administered if medication requested is not an oral agent:

☐ Home by home health ☐ Long-term care facility Other: ____

Renewal requests: Has disease progressed? ☐ Yes ☐ No Date of last office visit: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.