Iowa Department of Human Services

Request for Prior Authorization
SELECT ONCOLOGY AGENTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

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: _____

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:_____

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*