

# MASSACHUSETTS STANDARD FORM FOR CHEMOTHERAPY AND SUPPORTIVE CARE PRIOR AUTHORIZATION REQUESTS\*

*\*Providers may use the health plan's portal in place of this form.*

Request Date:	Treatment Start Date:	<input type="checkbox"/> Standard	<input type="checkbox"/> Expedited
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## I.

Health Plan Name:

Health Plan Phone:

Health Plan Fax:

## Member Information

First:	Last:	MI:
DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	
Height:	Weight:	BSA (m <sup>2</sup> ):
Diagnosis:	ICD-10:	Stage (0–4 or recurrent):
Insurance:	Line of Business (ex: Medicare):	Member ID:
*ECOG Score:	*Information in attached office note Yes <input type="checkbox"/>	
*Tumor Histology:		
*Allergies:		
*Comorbidities:		

## II. Anti-cancer Treatment Request    New: ☐    Retrospective: ☐    Re-Authorization: ☐

#	Billing Code/ J CODE	Administrative Code	Drug Name	Route	Dose	Frequency and Schedule	Cycles or Refills	Billing Method (B = Buy and Bill or P = Pharmacy)	FDA Approved for the Diagnosis?	For single use vials, is provider willing to dose round?
1								<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
2								<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
3								<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
4								<input type="checkbox"/> B <input type="checkbox"/> P	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown

III. Supporting Care Drugs Requested								
#	Billing Code/ J CODE	Administrative Code	Drug Name	Route	Dose	Frequency and Schedule	Condition (ex: Nausea)	Billing Method (B = Buy and Bill or P = Pharmacy)
1								<input type="checkbox"/> B <input type="checkbox"/> P
2								<input type="checkbox"/> B <input type="checkbox"/> P
3								<input type="checkbox"/> B <input type="checkbox"/> P
4								<input type="checkbox"/> B <input type="checkbox"/> P

If bone strengthening agents or bone antiresorptive agents are requested, select indication:  
☐ Osteo    ☐ Bone Metastases    ☐ Hypercalcemia    ☐ Adjuvant Breast Cancer

If ESAs requested, select indication:  
☐ CKD    ☐ Chemotherapy Induced Anemia (CIA)    ☐ MDS    ☐ Anemia of Chronic Disease (ACD)

IV. Provider and Place of Treatment Information	
Ordering Provider:	Specialty:
NPI #:	TIN #: DEA #:
Phone:	Fax:
Treating Provider: (if different)	Specialty:
NPI #:	TIN #:
Phone:	Fax:
Place of Treatment: (if different)	
NPI #:	TIN #:
Phone:	Fax:
Address of Treatment Center:	
Is the patient currently being treated with the requested regimen(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Line of Treatment:	
What therapies has the patient previously tried?	
Has the patient been screened for tumor mutations/biomarkers/genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If so, what tumor mutations/biomarkers/genetic testing result has the patient been tested for?	
If this is an out-of-network request, is this provider the only available treating/servicing provider within a reasonable distance that can provide this treatment/service for the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Has the member been receiving cancer treatments from the requesting treating provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Is treating provider in-network? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Site of Service: <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Home Infusion <input type="checkbox"/> Other _____	
Attachments: <input type="checkbox"/> Labs <input type="checkbox"/> Imaging <input type="checkbox"/> Chemo Orders <input type="checkbox"/> Pathology <input type="checkbox"/> Progress Notes	
Authorized Representative:	
Phone:	Fax:

## V. Exceptions to Step Therapy

*Please complete the applicable section(s).*

Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly describe details of contraindication, adverse reaction, or harm:

Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen? ☐ Yes ☐ No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen:

Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

If yes, please provide details for the previous trial:

**Drug Name:** \_\_\_\_\_ **Dates/Duration of Use:** \_\_\_\_\_

Did the member experience any of the following? ☐ Adverse Reaction ☐ Inadequate Response

Briefly describe details of adverse reaction or inadequate response:

**Drug Name:** \_\_\_\_\_ **Dates/Duration of Use:** \_\_\_\_\_

Did the member experience any of the following? ☐ Adverse Reaction ☐ Inadequate Response

Briefly describe details of adverse reaction or inadequate response:

Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly provide details of the adverse reaction or physical or mental harm:

***Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers must attach any additional data required relevant to medical necessity criteria, including PROGRESS NOTES, CHEMO ORDERS, LABS, PATHOLOGY, AND IMAGING RESULTS WITH REQUEST.***