

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type

Request Date: / /

- Initial Authorization Request Re-Authorization Request; List Prior Auth Ref # _____
- Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800-824-2642) FAX
- Ship Medication to: MD Office Patient's Home Other: (please specify)

1. PATIENT INFORMATION – ALL INFORMATION REQUIRED			
Patient Last Name	Patient First Name	Patient ID Number	Patient DOB / /
Contact Phone Number () -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight _____(lbs/kg) Patient's Height _____
2. PHYSICIAN INFORMATION – ALL INFORMATION REQUIRED			
Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address		City	State Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name and ext.	Physician Specialty
3. MEDICATION INFORMATION – ALL INFORMATION REQUIRED			
HCPCS Code/Drug Name J9263 - Eloxatin	Dose to be administered (mg/m ²)	When did the member first start this drug?	
Frequency (weeks)	Duration (weeks)	Start Date For This Request	
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____			
4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY. Answer questions based on the patient's diagnosis.			
NOTE: To avoid delays, please complete this form in its entirety.			
1. Gastric Cancer			
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been diagnosed with gastric cancer? If, yes , answer the following:			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used as post operative therapy? If, yes , answer the following: <input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used for margin negative resection for locoregional disease (T2 or higher by clinical staging or node positive)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient received pre-operative therapy with ECF (Epirubicin, Cisplatin and 5-FU) or its modifications?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used as pre-operative therapy? If, yes , answer the following: <input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used for locoregional disease (T2 or higher by clinical staging or node positive)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient medically fit?			
2. Colorectal Cancer			
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been diagnosed with colorectal cancer? If, yes , answer the following:			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used for neoadjuvant therapy? If, yes , answer the following: <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have synchronous liver or lung metastases? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have metachronous liver or lung metastases?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have advanced Stage III, IV or metastatic disease?			
3. Esophageal Cancer			
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been diagnosed with esophageal cancer? If, yes , answer the following:			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used for post operative therapy? If, yes , answer the following: <input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used for adenocarcinoma of lower esophagus or GE junction? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient received pre-operative therapy for resectable locoregional disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient Stage I to II or IVA? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this a component of modified ECF(Epirubicin, Cisplatin and 5-FU) regimen?			

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- Yes No Is this to be used for palliative therapy? **If, yes**, answer the following:
- Yes No Is this to be used for persistent local disease (no metastases)?
 - Yes No Is this to be used following initial treatment for resectable locoregional disease?
 - Yes No Is this to be used for Stage I to III or IVA?
 - Yes No Is the patient medically fit?
- Yes No Is this to be used for unresectable disease? **If, yes**, answer the following:
- Yes No Is this to be used following initial treatment for respectable locoregional disease?
 - Yes No Is this to be used for Stage I to III or IVA?
 - Yes No Is the patient medically fit?
- Yes No Is this to be used for metastatic disease? **If, yes**, answer the following:
- Yes No Is this to be used following initial treatment for respectable locoregional disease?
 - Yes No Is this to be used for Stage I to III or IVA?
 - Yes No Is the patient medically fit?
 - Yes No Is the Karnofsky performance greater than or equal to 60?
 - Yes No Is the ECOG performance score less than or equal to 2?
- Yes No Is this to be used for recurrent disease? **If, yes**, answer the following:
- Yes No Is the Karnofsky performance greater than or equal to 60?
 - Yes No Is the ECOG performance score less than or equal to 2?

4. Testicular Cancer

Yes No

Has the patient been diagnosed with testicular cancer? **If, yes**, answer the following:

- Yes No Is this to be used for palliative care?
- Yes No Is this to be used after first line salvage therapy?

5. Ovarian Cancer

Yes No

Has the patient been diagnosed with ovarian cancer? **If, yes**, answer the following:

- Yes No Is this to be used for recurrence therapy?
- Yes No Is this to be used as a single agent?
- Yes No Has the patient been disease free for 6 months? **If, yes**, answer the following:
 - Yes No Does the patient have low grade recurrence? **If, yes**, answer the following:
 - Yes No Is this to be used as immediate treatment?
 - Yes No Is this to be used after secondary cytoreductive surgery?
 - Yes No Is this to be used along with secondary cytoreductive surgery?
 - Yes No Does the patient have focal recurrence? **If, yes**, answer the following:
 - Yes No Is this to be used as immediate treatment?
 - Yes No Is this to be used after secondary cytoreductive surgery?
 - Yes No Is this to be used along with secondary cytoreductive surgery?
- Yes No Is this to be used for progressive or stable disease on primary chemotherapy?
- Yes No Is this to be used for relapse after being in complete remission following primary chemotherapy?
- Yes No Is this to be used for Stage II to IV disease showing partial response to primary treatment?

6. Non-Hodgkin's Lymphoma

Yes No

Has the patient been diagnosed with Non-Hodgkin's Lymphoma? **If, yes**, answer the following:

- Yes No Is the patient a candidate for high dose therapy with autologous stem cell rescue?
- Yes No Is this to be used as second line therapy? **If, yes**, answer the following:
 - Yes No Does the patient have diffuse large B-Cell lymphoma? **If, yes**, answer the following:
 - Yes No Is the disease relapsed or refractory?
 - Yes No Does the patient have follicular lymphoma and nodal marginal zone lymphoma? **If, yes**, answer the following:
 - Yes No Is the disease refractory or progressive?
- Yes No Does the patient have gastric MALT Syndrome? **If, yes**, answer the following:

PreDetermination of Medical Benefits

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Yes No Is the disease recurrent or progressive?

Yes No Does the patient have mantle cell lymphoma? **If, yes**, answer the following:

Yes No Is the disease relapsed, refractory, or progressive?

Yes No Does the patient have non-gastric MALT lymphoma? **If, yes**, answer the following:

Yes No Is the disease recurrent or progressive?

Yes No Does the patient have splenic marginal zone lymphoma? **If, yes**, answer the following:

Yes No Is the disease progressive?

7. Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

5. PHYSICIAN SIGNATURE

Prescriber's or Authorized Representative's Signature:

Date: ___/___/___

Prior Authorization 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.

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Medical Policy Reference can be found at: www.bcbsga.com.

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