



Medicare Advantage PPOSM Oncology Drug Prior Authorization Fast-Track Fax Form

Member name _____

Member ID _____ Date of Service _____

Diagnosis / CC _____

Medicare Advantage Care Mgmt Yes No If No, please make referral.

Name of 1st drug _____ **Code** _____

Dosage /Route _____

Plan of Treatment / Cycle _____

Meets Pharmaceutical Decision Support Tree (circle) YES NO N/A

- If yes, no further information is needed.
- If no, or N/A, please follow routine authorization procedures.
- DOS approved _____ Reference # _____
- Approved by _____ Date _____

Name of 2nd drug _____ **Code** _____

Dosage /Route _____

Plan of Treatment / Cycle _____

Meets Pharmaceutical Decision Support Tree (circle) YES NO N/A

- If yes, no further information is needed.
- If no, or N/A, please follow routine authorization procedures.
- DOS approved _____ Reference # _____
- Approved by _____ Date _____

Provider# _____ NPI# _____ Tax ID# (last 5 digits) _____

Contact _____ Phone _____ Fax _____

Call In Prior Authorizations 1-800-924-7141

Fax In Prior Authorizations 1-888-535-5243 or 1-423-535-5243

*This benefit determination was made in accordance with 42 CFR part 410. This organization determination is no longer valid if the member is no longer covered by Medicare Advantage.

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