# Prior Authorization/ Formulary Exception OHP Chemotherapy Request Form

**Fax to 503-416-4722**

For assistance with the form, you may call CareOregon at 503-416-4100 or 800-224-4840 — Monday through Friday from 8 am - 5 pm. CareOregon requests careful selection when checking urgent as it delays review of other requests that may seriously jeopardize the health of another member, please mark URGENT only as necessary.
**Please complete both pages legibly and we recommend providing supporting medical records.**
**CareOregon reviews all requests within 24 hours.**

☐ **Urgent Request:** By selecting the expedited review and signing this form below, I certify that applying the standard review will seriously jeopardize the life or health of the member. Both Standard and Urgent requests will be reviewed within 24 hours.

## Patient Information

Patient Name: _____ Member ID# _____

DOB: _____ Gender: ☐ Male ☐ Female Weight: _____

## Prescriber Information

Prescriber Name and Specialty: _____NPI: _____

Office Phone#: _____ Office Fax#: _____ Contact Person: _____

## Chemotherapy Regimen and Diagnosis

| | Drug Name | HCPC | Dose | Frequency | Total Units |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |

| | | |
|---|---|---|
| Start Date: | Duration: | Please check one: ☐ Curative ☐ Palliative |
| Diagnosis/ICD-10 Code(s): | | Current cancer status: |

## ECOG Performance Status

- ○ 0 Fully active, no restrictions
- ○ 1 Restricted in strenuous activity but ambulatory, able to carry out light work activities
- ○ 2 Ambulatory and capable of self-care but unable to carry out work activities
- ○ 3 Limited self-care, bed-bound 50% of waking hours
- ○ 4 Completely disabled, no self-care, bed-bound

## Place of Service

○ Infusion Center ○ Ambulatory Surgery Center (ASC) ○ Hospital Day Patient

Facility Name:_____

Anticipated or Actual Admit Date: _____

○ Home (picking up at pharmacy)

_____

_____

## Additional Office Services/Procedures In Conjunction With Administration

CPT Code(s): _____ #Visits: _____



*Continued >>*

## Palliative Care Services– Health Share CCO Members Only

Concurrent palliative care is recommended for advanced cancer patients with a prognosis of less than 24 months, whether treatment intent is to prolong life or simply to improve comfort.

**Has a referral to palliative/supportive care services been made?**

☐ **Yes**
- ◯ Adventist Health Options 503-251-6192
- ◯ Care Partners 503-648-9565
- ◯ Other: _____

☐ **No*** Reason: _____

*If No is checked above, CareOregon will review the case for consideration of palliative care services.

For CareOregon program brochures and referral forms:
*http://www.careoregon.org/Providers/ProviderFormsandPolicies.aspx*

## GUIDELINE NOTE 12

Per the **OHP Prioritized List of Health Services Guideline note 12**: Treatment with intent to prolong survival is not a covered service for patients who have progressive metastatic cancer with:

1. Severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy; OR
2. A continued decline in spite of best available therapy with a non reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.

**OAR 410-120-1200 (2) (a):** Excluded services and limitations: The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are (a) Not expected to significantly improve the basic health status of the client as determined by Division staff, or its contracted entities.

**To qualify for treatment coverage, please check that ALL of the following have been met:**

- ☐ The patient does NOT have severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy.
- ☐ The patient does NOT have severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy.
- ☐ There has been a documented discussion with the patient about treatment goals, treatment prognosis and the side effects, and knowledge of the realistic expectations of treatment efficacy.
- ☐ The prescribed treatment is provided via evidence-drive pathways (such as NCCN, ASCO, ASH, ASBMT, or NIH Guidelines) when available.

Please provide any other pertinent information and include medical records with your request.

_____

_____

_____

**Prescriber's Signature:** _____ **Date:** _____