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FLORIDA COMMUNITY CARE

FLORIDA MEDICAID PRIOR AUTHORIZATION

ORAL ONCOLOGY AGENTS

(Maximum Approval = One Year)

Note: Form must be completed in full. An incomplete form may be returned.

CVS caremark

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

Provider Specialty: _____

Medication Request: ○ **New** ○ **Continuation** **Ht**: _____ in _____ cm **Wt**: _____ lb _____ kg **BSA:** _____

1. **Medication Requested:**

Medication	Strength	Directions	# of Cycles	Quantity/Month

2. **Diagnosis**

☐ Breast Cancer ☐ Renal Cancer ☐ Prostate Cancer ☐ Lung Cancer ☐ Ovarian Cancer

☐ Leukemia ☐ Other Diagnosis: _____

3. **Previous Medication Trials**

Medication	Strength	Directions	Start/End Dates	Maximum Dose (Per Day)

4. **List all other medications the patient is taking concurrently with the antineoplastic:**

Medication	Strength	Directions	# of Cycles

PRESCRIBER'S SIGNATURE **DATE**

REQUIRED FOR REVIEW: Copies of medical records (i.e. diagnostic evaluations and recent chart notes), and the most recent copies of related labs

The provider must retain copies of all documentation for five years.

Call or Fax Information to: Florida Community Care Prior Authorization
Phone number for non-specialty Prior Authorization: 877-433-7643
Phone number for specialty Prior Authorization: 866-814-5506
Fax number for non-specialty Prior Authorization: 866-255-7569
Fax number for non-specialty Prior Authorization: 866-249-6155

For AHCA Use Only

DATE: _____ **NOTIFIED:** _____

APPROVED: _____ **START DATE:** _____ **EXPIRATION DATE:** _____

DENIED: _____ **REASON:** _____