coordinated care.

Antineoplastics and Adjunctive Therapies- Imidazotetrazines– Oral

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720.
You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of a positive clinical response? ☐ Yes ☐ No

2. What is the patient's diagnosis (ICD code plus description)?
   Indicate stage:
   Indicate disease type (i.e. New onset, refractory, etc.):

3. Is this being used in combination with other chemotherapeutic, radiotherapeutic, or adjuvant agents?
   ☐ Yes ☐ No
   If yes, list all therapies:

4. List treatments patient has previously tried and dates these treatments were started:
   How long was the patient on these treatments?

   Why were they stopped or discontinued?

   If agent was stopped for lack of benefit, include documentation of what measures were used to define a positive clinical response and what the change was from baseline.

5. Has the diagnosis and staging been confirmed with either an FDA approved companion diagnostic test, medically necessary test to confirm a gene-mutation or any other companion tests used for concurrent or previous treatments?
   ☐ Yes ☐ No
   Attach labs and results of all diagnostic tests performed to confirm diagnosis.

6. Is there a contraindication to the requested medication or any other medications that are part of the patient's regimen? ☐ Yes ☐ No
   If yes, indicate contraindication(s):

7. What is the patient's planned dosing regimen?

8. Has this medication been prescribed by, or in consultation with a specialist in oncology or neurology?
   ☐ Yes ☐ No

9. Indicate for patient: Height (cm): **Date taken:** Weight (kg): **Date taken:** Body surface area (m^2): **Date taken:**		
CHART NOTES, LABS AND RESULTS OF DIAGNOSTIC TESTS ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)