# Oncology Agents: Antimetabolites - Oral

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

*Coordinated Care of Washington, Inc. (Apple Health) Preferred Drug list*:
https://www.coordinatedcarehealth.com/providers/pharmacy.html

*For policy criteria, see:* https://www.coordinatedcarehealth.com/content/coordinatedcare/en_us/providers/resources/clinical-payment-policies.html/

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|---|---|---|---|
| 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 therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response [e.g., patient remains in remission, stabilization of disease, lack of disease progression]?
   ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Hematologist ☐ Oncologist ☐ Other. Specify: _____

3. What is patient current weight: _____kg Date taken: _____

4. Indicate patient's diagnosis:
   ☐ Acute myeloid leukemia
   ☐ Other. Specify: _____

**For azacitadine:**

5. Indicate the following for patient:
   ☐ Receiving continued treatment after achieving first complete remission
   ☐ Achieved complete remission with incomplete blood count recovery following intensive induction chemotherapy and are unable to complete intensive curative therapy

**For thioguanine:**

6. Is patient is receiving therapy for induction or consolidation therapy? ☐ Yes ☐ No

**CHART NOTES ARE REQUIRED WITH THIS REQUEST**

| Prescriber signature | Prescriber specialty | Date |
| --- | --- | --- |
| | | |

Centene 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.)