FLORIDA MEDICAID PRIOR AUTHORIZATION

ORAL ONCOLOGY AGENTS

(Maximum Approval = One Year)

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

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), the original prescription, and the most recent copies of related labs

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

Fax or mail completed forms to:

Magellan Medicaid Administration, Inc.
Prior Authorization
P.O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

For AHCA Use Only

DATE: _____ **NOTIFIED:** _____

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

DENIED: _____ **REASON:** _____