



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Provider Specialty: _____

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

1. Medication Requested:

Table with 5 columns: 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

Table with 5 columns: Medication, Strength, Directions, Start/End Dates, Maximum Dose (Per Day)

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

Table with 4 columns: 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.

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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: