Oncology Step Therapy Exception Prior Authorization Form

To file electronically, attach to request submitted in secure online portal (PAAN): www.UHCProvider.com/PAAN	To file via facsimile, send to 1-855-352-1206

To contact the coverage review team for your health plan please call the toll-free number on your medical ID card between the hours of 8am-5pm PST time. For after-hours review, please call the number on your health plan ID card.

(1) Priority and Frequency:							
a. Standard	☐	**Services scheduled for this date:**					
b. Urgent/Expedited	☐	**Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.**					
c. Frequency:	**Initial:**	☐	**Extension:**	☐	**Previous Authorization #:**		
(2) Enrollee Information:							
a. Enrollee Name:		**b. Enrollee date of birth:**		**c. Subscriber/ Member ID#:**			
d. Enrollee Street Address:							
e. City:		**f. State:**		**g. Zip Code:**			
(3) Provider Information:	**Ordering Provider:**	☐	**Rendering Provider:**	☐	**Both**	☐	

Please note: Exception requests are to be submitted under urgent status through phone, fax, or web portal. Step therapy Exception requests are limited to members with stage 3 or stage 4 cancer and require the following information: progress notes, laboratory results, radiology results, previous medications, and other factors impacting the plan of care. Processing delays may occur if the requestor (e.g. rendering provider, ordering provider, or member) does not have appropriate documentation of medical necessity.

Please note: Requests are reviewed by Registered Nurses, Pharmacists, and Board Certified Oncologists.

a. Provider Name:		**b. Provider Type/Specialty**			
c. Administrative Contact:		**d. NPI #:**		**e. DEA # (if applicable)**	
f. Clinic/ Facility Name:		**g. Clinic/Pharmacy Facility Street Address:**			
h. City/State/Zip:		**i. Phone Number/Extension**			
j. Facsimile/Email:					

(4) Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if requesting a drug).

a. Service Description:											
b. Setting/CMS POS Code:	**Outpatient:**	☐	**Inpatient:**	☐	**Home:**	☐	**Office:**	☐	**Other*:**	☐	
c. *Please specify if other:											

(5) HCPCS/CPT/ICD-10 CODES:

a. Latest ICD-10 Code	b. HCPCS/CPT/CDT Code	c. Medical Reason

(6) Frequency/Quantity/Repetition Request:						
a. Does this service involve multiple treatments?	**Yes:**	☐	**No:**	☐	**If "No," skip to Section 7.**	
b. Type of Service:		**c. Name of Therapy/Agency:**				
d. Units/Volume/Visits Requested:		**e. Frequency/Length of Time Needed:**				

(8) Prescription Drug:											
a. Diagnosis Name and Code:											
b. Patient Height (if required):		**c. Patient Weight (if required):**									
d. Route of Administration:	**Oral/SL:**	☐	**Topical:**	☐	**Injection:**	☐	**IV:**	☐	**Other*:**	☐	
***Please explain if "other:"**											
e. Administrated:	**Doctor's Office:**	☐	**Dialysis Center:**	☐	**Home Health Hospice:**	☐	**By Patient:**	☐			

f. Medication Requested	**g. Strength (include both loading and maintenance dosage)**	**h. Dosing Schedule (including length of therapy)**	**i. Quantity per month or Quantity Limits**

j. Is the patient currently treated with the requested medication(s):	**Yes*:**	☐	**No:**	☐
***If "Yes," when was the treatment with the requested medication started? Date:**				
k. Anticipated medication start date (MM/DD/YY):				

l. General prior authorization request. Explain the clinical reason(s) for the requested medications, including an explanation for selecting these medications over alternatives:

m. Rationale for drug formulary or step-therapy exception request:

☐	**Alternative drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure.**	
	Please specify: **(1) Drug(s) contraindicated or tried;** **(2) Adverse outcome for each;** **(3) If therapeutic failure, length of therapy on each drug(s).**	
☐	**Patient is stable on current drug(s), high risk of significant adverse clinical outcome with medication change.**	
	Specify anticipated significant adverse clinical outcome:	
☐	**Medical need for different dosage and/or higher dosage.**	
	Specify: (1) Dosage(s) tried; (2) Explain medical reason:	
☐	**Request for formulary exception. Please specify:**	
	(1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; **(2) If therapeutic failure, length of therapy on each drug and adverse outcome;** **(3) If not as effective, length of therapy on each drug and outcome.**	
☐	**Other. Please Explain:**	

n. List any other medications patient will use in combination with requested medication:

o. List any known drug allergies:

(9) Previous services/therapy (including drug, dose, durations, and reason for discontinuing each previous service/therapy)?

a.		**Date Discontinued:**	
b.		**Date Discontinued:**	
c.		**Date Discontinued:**	

(10) Attestation:
I hereby certify and attest that all information provided as part of this prior authorization is true and accurate.

Requester Signature:		**Date:**	

DO NOT WRITE BELOW THIS LINE. FIELDS TO BE COMPLETED BY PLAN.

Authorization #:		**Contact Name:**	
Contact's credentials/designation:			