MASSACHUSETTS STANDARD FORM FOR CHEMOTHERAPY AND SUPPORTIVE CARE PRIOR AUTHORIZATION REQUESTS*

**Providers may use the health plan's portal in place of this form.*

Request Date:	Treatment Start Date:	☐ Standard	☐ Expedited

I.	
Health Plan Name:	
Health Plan Phone:	Health Plan Fax:

Member Information		
First:	Last:	MI:
DOB:	Gender: ☐ M ☐ F ☐ Unknown ☐ Other: _____	
Height:	Weight:	BSA (m^2):
Diagnosis:	ICD-10:	Stage (0–4 or recurrent):
Insurance:	Line of Business (ex: Medicare):	Member ID:
*ECOG Score:	*Information in attached office note Yes ☐	
*Tumor Histology:		
*Allergies:		
*Comorbidities:		

II. Anti-cancer Treatment Request **New:** ☐ **Retrospective:** ☐ **Re-Authorization:** ☐

#	Billing Code/ J CODE	Administrative Code	Drug Name	Route	Dose	Frequency and Schedule	Cycles or Refills	Billing Method (B = Buy and Bill or P = Pharmacy)	FDA Approved for the Diagnosis?	For single use vials, is provider willing to dose round?
1								☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown
2								☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown
3								☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown
4								☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown

(continued on next page)

III. Supporting Care Drugs Requested

#	Billing Code/ J CODE	Administrative Code	Drug Name	Route	Dose	Frequency and Schedule	Condition (ex: Nausea)	Billing Method (B = Buy and Bill or P = Pharmacy)
1								☐ B ☐ P
2								☐ B ☐ P
3								☐ B ☐ P
4								☐ B ☐ P

If bone strengthening agents or b one antiresorptive agents are requested, select indication:
☐ Osteo ☐ Bone Metastases ☐ Hypercalcemia ☐ Adjuvant Breast Cancer

If ESAs requested, select indication:
☐ CKD ☐ Chemotherapy Induced Anemia (CIA) ☐ MDS ☐ Anemia of Chronic Disease (ACD)

IV. Provider and Place of Treatment Information

Ordering Provider:

NPI #:	TIN #:	DEA #:
Phone:	Fax:	

Treating Provider: (if different)

NPI #:	TIN #:
Phone:	Fax:

Place of Treatment: (if different)

NPI #:	TIN #:
Phone:	Fax:

Address of Treatment Center:

Is the patient currently being treated with the requested regimen(s)? ☐ Yes ☐ No ☐ Unknown

Line of Treatment:

What therapies has the patient previously tried?

Has the patient been screened for tumor mutations/biomarkers/genetic testing? ☐ Yes ☐ No ☐ Unknown

If so, what tumor mutations/biomarkers/genetic testing result has the patient been tested for?

_____

If this is an out-of-network request, is this provider the only available treating/servicing provider within a reasonable distance that can provide this treatment/service for the patient? ☐ Yes ☐ No ☐ Unknown

Has the member been receiving cancer treatments from the requesting treating provider? ☐ Yes ☐ No ☐ Unknown

Is treating provider in-network? ☐ Yes ☐ No ☐ Unknown

Site of Service: ☐ Outpatient Hospital ☐ Home Infusion ☐ Other _____

Attachments: ☐ Labs ☐ Imaging ☐ Chemo Orders ☐ Pathology ☐ Progress Notes

Authorized Representative:

Phone:	Fax:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers must attach any additional data required relevant to medical necessity criteria, including PROGRESS NOTES, CHEMO ORDERS, LABS, PATHOLOGY, AND IMAGING RESULTS WITH REQUEST.