PRIOR AUTHORIZATION/ FORMULARY EXCEPTION

OHP Chemotherapy Request Form

FAX to 503-416-4722

(Revised on 09/11/2015)

CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

For assistance with the form, you may call CareOregon at 503.416.4100 or 800.224.4840 - Monday through Friday from 8 am - 5 pm. CareOregon requests careful selection when checking urgent as it delays review of other requests that may seriously jeopardize the health of another member, please mark URGENT only as necessary.

**** Please complete both pages legibly and we recommend providing supporting medical records. ****

A standard request may take up to 3 days to process, but the average process time is less than 24 hours.

☐ **URGENT** By selecting the expedited review and signing this form below, I certify that applying the standard review time frame will seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name and Specialty:
Member ID#:	NPI#:
Sex: ☐ Male ☐ Female	Office Phone:
Date of Birth:	Office Fax:
Weight:	Contact Person:

CHEMOTHERAPY REGIMEN AND DIAGNOSIS

Drug Name	HCPC	Dose	Frequency	Total Units
1.				
2.				
3.				
4.				

Start Date:	Duration:	Please check one: ☐ Curative ☐ Palliative

Diagnosis/ICD-10 Code(s):	Current cancer status:

ECOG Performance Status:

- ☐ 0 Fully active, no restrictions
- ☐ 1 Restricted in strenuous activity but ambulatory, able to carry out light work activities
- ☐ 2 Ambulatory and capable of self-care but unable to carry out work activities
- ☐ 3 Limited self-care, bed-bound 50% of waking hours
- ☐ 4 Completely disabled, no self-care, bed-bound

PLACE OF SERVICE

☐ Infusion Center ☐ Ambulatory Surgery Center (ASC) ☐ Hospital Day Patient

Facility Name: ______________________________

Anticipated or Actual Admit Date, if known: __________________

☐ Home (picking up at pharmacy)

ADDITIONAL OFFICE SERVICES/PROCEDURES IN CONJUNCTION WITH ADMINISTRATION

CPT code(s):	# Visits:

CONTINUE TO PAGE 2

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PALLIATIVE CARE SERVICES– HEALTH SHARE CCO MEMBERS ONLY

Concurrent palliative care is recommended for advanced cancer patients with a prognosis of less than 24 months, whether treatment intent is to prolong life or simply to improve comfort.

Has a referral to palliative/supportive care services been made? ☐ Yes ☐ Adventist Health Options 503-251-6192
☐ Care Partners 503-648-9565
☐ Other: ______________________________

☐ No* Reason: ________________________________

* If No is checked above, CareOregon will review the case for consideration of palliative care services.

For CareOregon program brochures and referral forms: http://www.careoregon.org/Providers/ProviderFormsandPolicies.aspx

GUIDELINE NOTE 12

Per the **OHP Prioritized List of Health Services Guideline note 12**: Treatment with intent to prolong survival is not a covered service for patients who have progressive metastatic cancer with

1. Severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy; OR
2. A continued decline in spite of best available therapy with a non reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.

OAR 410-120-1200 (2) (a): Excluded services and limitations: The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are (a) Not expected to significantly improve the basic health status of the client as determined by Division staff, or its contracted entities.

To qualify for treatment coverage, please check that ALL of the following have been met:

☐ The patient does **NOT** have severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy.

☐ The patient has **NOT** had a continued decline in spite of best available therapy with a non-reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.

☐ There has been a documented discussion with the patient about treatment goals, treatment prognosis and the side effects, and knowledge of the realistic expectations of treatment efficacy.

☐ The prescribed treatment is provided via evidence-drive pathways (such as NCCN, ASCO, ASH, ASBMT, or NIH Guidelines) when available.

Please provide any other pertinent information and include medical records with your request.

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Prescriber's Signature: Date:

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