FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Oral Chemotherapy Agents with Intravenous (IV) Equivalents Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Provide the diagnosis: _________________________________ ICD-10 Code(s): _______________________________

Clinical Information:

Does the requested medication contain the same active ingredient(s) as the non-self-administrable anti-cancer intravenous chemotherapeutic drug? ❑ **Yes** ❑ **No**

Please note: The oral anticancer drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium, or it is a prodrug which, when ingested, is metabolized into the same active ingredient which is found in the non-self-administrable form of the drug

Is the requested medication used for the same anti-cancer chemotherapeutic FDA approved indications, including "off-label" uses, as the non-self-administrable form of the drug? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by a practitioner licensed under state law to prescribe such drugs as anti-cancer chemotherapeutics? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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