



Authorization Request Medical Oncology



Please fax this completed form with treatment order, progress notes, imaging results, and lab/genetic reports to 800.695.4997.
We recommend all requests be submitted online at: www.healthhelp.com/phpmedicare

Request Type: Standard Expedited (please fax 855.546.7092 for immediate handling)

By checking the expedited box, the requestor certifies that applying standard review timeframe may seriously jeopardize the life and health of the member or the member's ability to regain maximum function.

To handle after hours requests, HealthHelp will have dedicated after hours services and on call nurses available.

Date of Request:		Treatment Start Date:		
PLEASE PROVIDE BEST CONTACT INFORMATION				
Requestor Name:		Direct Phone:	Email:	
PATIENT INFORMATION				
Patient Name:				
Patient ID:		Patient Date of Birth:		
ORDERING PHYSICIAN				
Physician Name:		NPI:		
Ordering Facility Name:		Tax ID:		
Facility Address:				
Cell Phone:	Fax:	Email:		
RENDERING FACILITY (<input type="checkbox"/> Same as Ordering Physician)				
Facility Name:		Tax ID:		
Facility Address:				
Phone:		Fax:		
Treatment Location: <input type="checkbox"/> Physician Office <input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Free Standing Facility				
CLINICAL INFORMATION				
Patient Height:		Patient Weight:		
Cancer Type:		Diagnosis Code (ICD-10):		
Cancer Stage:		Metastasis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Met Location:	
Treatment: <input type="checkbox"/> New <input type="checkbox"/> Continuation, Cycle:		Clinical Trial: <input type="checkbox"/> Yes <input type="checkbox"/> No		
TREATMENT REQUEST				
Treatment (include code) J9060 Cisplatin	Dose 50 mg	Treatment Frequency Day 1, Every 21 Days	Cycles 4	Dispense Location <input checked="" type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy
				<input type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy
				<input type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy
				<input type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy
				<input type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy
				<input type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy
				<input type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy
				<input type="checkbox"/> Treatment Site <input type="checkbox"/> Pharmacy

Confidentiality Notice

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Please ensure you are entering the correct fax number or that the correct fax number is programmed in your system prior to sending a fax to avoid HIPAA privacy incidents. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify the sender immediately and destroy the related message.