Outpatient Chemotherapy Preauthorization Form

Please complete this form in its entirety. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained from Avera Health Plans. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: _____ Date of Birth: _____

Member ID Number: _____ Group Number: _____

ICD code(s), please list all that apply: _____

Where will chemotherapy be given? _____

Please complete the following:

Chemotherapy protocol (i.e. R-CHOP): _____ Chemotherapy Start Date: _____

Number of chemotherapy cycles requested: _____ Each chemotherapy cycle lasts how many days? _____

Chemotherapy Agent	HCPCS	Dose & Schedule

Previous Chemotherapy Protocols tried, if applicable (doses & dates not needed):

_____

Is the requested chemotherapy protocol recognized by NCCN? ☐ Yes ☐ No

If not, please explain and provide supporting clinical documentation: _____

_____

Determination of medical necessity requires the submission of documentation.

☐ Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records: _____

☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Prescriber Name: _____ Today's Date: _____

Person completing the form: _____ Your Office/Facility Name: _____

Your Phone Number: (_____) _____ Your Fax Number: (_____) _____

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim by Avera Health Plans. If you have questions about your benefits, please contact Avera Health Plans Service Center at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorizations. Refer to patient's Certificate of Coverage or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send secure email to Pharmacy@AveraHealthPlans.com.