United Healthcare Community Plan

Oncology Agents: Antimetabolites - Oral – Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response [e.g., patient remains in remission, stabilization of disease, lack of disease progression]?
   ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Hematologist ☐ Oncologist ☐ Other. Specify: _____

3. What is patient current weight: _____kg Date taken: _____

4. Indicate patient's diagnosis:
   ☐ Acute myeloid leukemia
   ☐ Other. Specify: _____

For azacitadine:

5. Indicate the following for patient:
   ☐ Receiving continued treatment after achieving first complete remission
   ☐ Achieved complete remission with incomplete blood count recovery following intensive induction chemotherapy and are unable to complete intensive curative therapy

For thioguanine:

6. Is patient is receiving therapy for induction or consolidation therapy? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date