Reset Form | Print Form

United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

# ORAL ONCOLOGY AGENTS

**(Maximum Approval = One Year)**

**Note: Form must be completed in full. An incomplete form may be returned.**

**Recipient's Medicaid ID#**

**Date of Birth (MM/DD/YYYY)** ___ / ___ / ____

**Recipient's Full Name**

**Prescriber's Full Name**

**Prescriber's NPI**

**Prescriber Phone Number** ___ - ___ - ____

**Prescriber Fax Number** ___ - ___ - ____

**Provider Specialty:** _____

**Medication Request:** **New** **Continuation** **Ht**: _____ in _____ cm **Wt**: _____ lb _____ kg **BSA:** _____

**1. Medication Requested:**

| Medication | Strength | Directions | # of Cycles | Quantity/Month |
|---|---|---|---|---|
| | | | | |
| | | | | |

**2. Diagnosis**

☐ Breast Cancer ☐ Renal Cancer ☐ Prostate Cancer ☐ Lung Cancer ☐ Ovarian Cancer

☐ Leukemia ☐ Other Diagnosis: _____

**3. Previous Medication Trials**

| Medication | Strength | Directions | Start/End Dates | Maximum Dose (Per Day) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**4. List all other medications the patient is taking concurrently with the antineoplastic:**

| Medication | Strength | Directions | # of Cycles |
|---|---|---|---|
| | | | |
| | | | |

**Prescriber's Signature:** _____ **Date:** _____

**REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.**



Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

02.01.2025

**For AHCA Use Only**

**DATE:** _____ **NOTIFIED:** _____

**APPROVED:** _____ **START DATE:** _____ **EXPIRATION DATE:** _____

**DENIED:** _____ **REASON:** _____