CHEMOTHERAPY TREATMENT REQUEST FORM

ONCOLOGY MEDICATIONS FOR COUNTYCARE MEDICARE MEMBERS ONLY

Phone #: **888-999-7713** Fax #: **702-726-5186**

Date (mm/dd/yyyy):______/_______/_________

Member Name:

DOB(mm/dd/yyyy):______/_______/_________

Health Plan ID#:

Medicare: Private Fee for Service:

Advance Coverage Determination: [ ] Yes [ ] No

Height____ft____in **Weight________lbs**

Allergies: [ ]
____

NKA: [ ]

Requesting Provider:

Contact Name:

Phone:

Fax:

Backline:

Provider Address:

Type of Treatment: [ ]Initial [ ] Continuation of Treatment [ ]Subsequent

Site of Administration:
[ ]Provider's Office
[ ]Self-Administered
[ ]Outpatient (Center Name)
____
[ ]Other
____

Primary Diagnosis

Secondary Diagnosis

Treatment Start Date:

To help streamline the authorization process, please register to use our on-line at:
https://my.newcenturyhealth.com

Continuous Infusions IV Pump Required:
[ ] Yes [ ]No

ECOG/Performance Status:(please circle one): 0 1 2 3 4 5

Clinical Staging [ ]1 [ ]2 [ ]3 [ ]4

Intent to Treat
[ ]Adjuvant [ ]Curative [ ]Recurrent/Metastatic/Palliative

Clinical Trial [ ]Yes [ ]No

If Yes, Clinical Trial Name:________________________________

Values

Her2 Overexpressed	Yes [ ] No [ ]
EGFR	Positive [ ] Negative [ ]
ER	Positive [ ] Negative [ ]
PR	Positive [ ] Negative [ ]
K-RAS Wild Type	Yes [ ] No [ ]

[ ] Testing not applicable for request

This form must be completed in its entirety in order to process your request. Please fax your request to NCH to **877-624-0611**.
THIS IS NOT A GUARANTEE OF ELIGIBILITY. PLEASE VERIFY ELIGIBILITY BEFORE PERFORMING SERVICES.

New Century Health

CHEMOTHERAPY TREATMENT REQUEST FORM

ONCOLOGY MEDICATIONS FOR SIMPLY MEDICARE MEMBERS ONLY

Phone #: **888-999-7713** Fax #: **702-726-5186**

J Code	Drug Name	Dose	Directions for use (Please include Directions for Use)	Buy and Bill	Patient Acquired from Pharmacy	Physician Acquired from Pharmacy	Number of Cycles	Number of Doses
Chemotherapy (pre-meds and antiemetics)								
Growth Factors: ESA: - Must provide recent HgB/HcT Myeloid Growth Factors: Must provide CBC								
Other Medications:								

Physician's Signature (required) ______________________________

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