1. What is the member’s diagnosis?
______________________________________________________________________________________________

2. Is the disease advanced?  Yes or No

3. Is the disease metastatic?  Yes or No

4. Has the disease progressed on previous therapy? Yes or No

5. What other drug(s) or treatment(s) has the member previously received for this diagnosis?
______________________________________________________________________________________________
______________________________________________________________________________________________

6. Will the member be receiving any other drug(s) or treatment(s) with the requested drug? Yes or No
   a. If Yes, please provide the name(s) of the drug(s) and/or treatment(s) the member will be receiving:
      _______________________________________________________________________________________
      _______________________________________________________________________________________
      _______________________________________________________________________________________

7. Please provide information regarding tumor type, receptor status and/or genetic mutations. (e.g., HER2, estrogen/progesterone, Philadelphia chromosome, RAS, etc.):
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

8. How many days are in each chemotherapy cycle? ________________________________

9. Which days in each chemotherapy cycle will the member be receiving the requested drug? ______________

10. How many chemotherapy cycles of the requested regimen has the member received in the past? ____________

11. How many cycles of the requested drug are being requested? ________________________________

12. What stage is the member’s cancer? ________________________________

13. What phase of chemotherapy is the member receiving (e.g., induction, consolidation, maintenance, adjuvant, neoadjuvant, etc)? ________________________________

14. Is the cancer recurrent? Yes or No

Continued on p. 2
Member Name: ___________________________ Member ID: ____________ Member DOB: ______________

Drug Name: ___________________________ Strength: ___________ Directions: __________________________

Physician Name: __________________________ Physician Phone #: ___________________ Specialty: ____________

Physician Fax #: ____________ Pharmacy Name: ___________________________ Pharmacy Phone: ______________

15. Has the member previously had surgery for the cancer?
   □ Yes – Specify type of surgery: __________________________________________________________
   □ No - Is surgery/resection an option for the cancer? ______________________________________

16. For members with Breast Cancer, please answer the following questions:
   a. Is the member PR (progesterone receptor) positive or negative? __________________________
   b. Is the member ER (estrogen receptor) positive or negative? ______________________________
   c. Is the member HER2 positive or negative? __________________________
   d. Please indicate the member’s menopausal status:
      ☐ pre-menopausal, ☐ peri-menopausal, or ☐ post-menopausal
   e. Does the member have high tumor burden?    __________________________
   f. Does the member have rapidly progressing disease? __________________________
   g. Does the member have visceral crisis?  __________________________

17. Please provide any other pertinent clinical information regarding the member’s diagnosis.
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

18. Please provide the member’s current weight and height:
   Weight: _______ lbs or _______kg. Date Taken: ___________________
   Height: _______ inches or _______cm. Date Taken: ___________________

*Form must be completed and signed by physician or licensed representative from the physician’s office
**Complete Page 2 for Subsequent/Renewal Requests**

1. What is the member’s diagnosis?

2. Has the member shown stabilization of the disease or clinical improvement (i.e. slowing of disease progression or decrease in symptom severity and/or frequency)?  Yes or No

3. Please provide the member’s current weight and height:
   - Weight: _______ lbs or _______ kg.  Date Taken: ________________
   - Height: _______ inches or _______ cm.  Date Taken: ________________

*Form must be completed and signed by physician or licensed representative from the physician’s office*