WellSense HEALTH PLAN

Phone: 877-417-0528 (Clarity plans)
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MASSACHUSETTS STANDARD FORM FOR CHEMOTHERAPY AND SUPPORTIVE CARE PRIOR AUTHORIZATION REQUESTS*

**Providers may use the health plan's portal in place of this form.*

Request Date:	Treatment Start Date:	☐ Standard	☐ Expedited

I.	
Health Plan Name:	
Health Plan Phone:	Health Plan Fax:

Member Information		
First:	Last:	MI:
DOB:	**Sex assigned at birth: ☐ Male ☐ Female ☐ "X" or Intersex** **Current Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other[1]**	
Height:	Weight:	BSA (m^2):
Diagnosis:	ICD-10:	Stage (0–4 or recurrent):
Insurance:	Line of Business (ex: Medicare):	Member ID:
*ECOG Score:	*Information in attached office note Yes ☐	
*Tumor Histology:		
*Allergies:		
*Comorbidities:		

1 Plans do not discriminate based on race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

II. Anti-cancer Treatment Request New: ☐ Retrospective: ☐ Re-Authorization: ☐

#	Billing Code/ J CODE	Administrative Code	Route	Dose	Frequency and Schedule	Cycles or Refills	Billing Method (B=Buy and Bill or P = Pharmacy)	FDA Approved for the Diagnosis?	For single use vials, is provider willing to dose round?
1							☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown
2							☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown
3							☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown
4							☐ B ☐ P	☐ Y ☐ N	☐ Y ☐ N ☐ Unknown

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III. Supporting Care Drugs Requested

#	Billing Code/ J CODE	Administrative Code	Drug Name	Route	Dose	Frequency and Schedule	Condition (ex: Nausea)	Billing Method (B = Buy and Bill or P = Pharmacy)
1								☐ B ☐ P
2								☐ B ☐ P
3								☐ B ☐ P
4								☐ B ☐ P

If bone strengthening agents or b one antiresorptive agents are requested, select indication:
☐ Osteo ☐ Bone Metastases ☐ Hypercalcemia ☐ Adjuvant Breast Cancer

If ESAs requested, select indication:
☐ CKD ☐ Chemotherapy Induced Anemia (CIA) ☐ MDS ☐ Anemia of Chronic Disease (ACD)

IV. Provider and Place of Treatment Information

Ordering Provider:

NPI #:	TIN #:	DEA #:
Phone:	Fax:	

Treating Provider: (if different)

NPI #:	TIN #:
Phone:	Fax:

Place of Treatment: (if different)

NPI #:	TIN #:
Phone:	Fax:

Address of Treatment Center:

Is the patient currently being treated with the requested regimen(s)? ☐ Yes ☐ No ☐ Unknown

Line of Treatment:

What therapies has the patient previously tried?

Has the patient been screened for tumor mutations/biomarkers/genetic testing? ☐ Yes ☐ No ☐ Unknown

If so, what tumor mutations/biomarkers/genetic testing result has the patient been tested for?

_____

If this is an out-of-network request, is this provider the only available treating/servicing provider within a reasonable distance that can provide this treatment/service for the patient? ☐ Yes ☐ No ☐ Unknown

Has the member been receiving cancer treatments from the requesting treating provider? ☐ Yes ☐ No ☐ Unknown

Is treating provider in-network? ☐ Yes ☐ No ☐ Unknown

Site of Service: ☐ Outpatient Hospital ☐ Home Infusion ☐ Other _____

Attachments: ☐ Labs ☐ Imaging ☐ Chemo Orders ☐ Pathology ☐ Progress Notes

Authorized Representative:

Phone:	Fax:

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V. Exceptions to Step Therapy

Please complete the applicable section(s).

Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly describe details of contraindication, adverse reaction, or harm:

Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regiment? ☐ Yes ☐ No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

If yes, please provide details for the previous trial:

Drug Name: **Dates/duration of use:**

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response:

Drug Name: **Dates/duration of use:**

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response:

Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly provide details on the member's stability and the likely adverse reaction or physical or mental harm:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers must attach any additional data required relevant to medical necessity criteria, including PROGRESS NOTES, CHEMO ORDERS, LABS, PATHOLOGY, AND IMAGING RESULTS WITH REQUEST.