OPTUM Care™

Authorization Request Coordination ARC+

TREATMENT REQUEST FORM
CHEMOTHERAPEUTIC AGENTS

Phone: (877) 370-2845
Fax: (888) 992-2809

Please mark one of the following:

□ Routine (normal, non-urgent request)
□ Date sensitive (date sensitive is defined as an upcoming date of service)
□ Urgent (urgent is defined as significant impact to health of the member if not completed within 72 hours)

Today's Date _____
Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell: _____ Work: _____
Date of Birth: _____ Sex: □ M □ F
Allergies: _____
Weight: _____ (lbs/kg) Height: _____ BSA: _____ (m^2)
Deliver Rx to: N/A

Physician Name: _____
TIN: _____
DEA: _____
Name of Practice: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____
Office Contact: _____

Medical History	Primary Dx: (ICD-10) (Description)	**Current Stage of Cancer:** **TNM (if applicable):**
	Secondary Dx: (ICD-10) (Description)	**Estimated Duration of Therapy:** **Date of Next Treatment:**
This is For: □ New Diagnosis and Treatment □ Continuation of Treatment		**Intent to Treat:** □ Neoadjuvant □ Adjuvant □ Metastic but Curative Intent □ Palliative

Select from the following commonly used medications: (Please include all medications to be used in the patient's therapy)

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Cycles
Pre-meds and Anti-Emetics					
□ Diphenhydramine	J1200				
□ Dexamethasone	J1100				
□ Ondansetron	J2405				
□ Granisetron	J1626				
□ Palonosetron	J2469				
□ Foraprepitant	J1453				
□ Other:					
Parenteral Chemotherapy (Please list the chemotherapy regimen below and attach any applicable labs)					

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	
Growth Factor Medications (Must attach recent lab values)					
☐ Neupogen (filgrastim)	J1440	300mcg			
☐ Neupogen (filgrastim)	J1441	480mcg			
☐ Neulasta (pegfilgrastim)	J2505				
☐ Procrit	J0885				
☐ Aranesp	J0881				
☐ **Unless indicated, Generic Substitution Allowed**					
Please attach a copy of the patient's insurance card.					

Physician's Signature (On File)_____(Physician signature required to validate prescriptions)

This form must be completed in its entirety, as it may be forwarded to the Health Plan for authorization. This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and/or telephone number set forth herein and obtain instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.