



**Outpatient Chemotherapy  
Chemotherapy Request Form  
Fax to 833-581-1861  
(Medical Benefit Only)**

Member Name: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_

Member ID (UMI): \_\_\_\_\_ ☐ Medicare ☐ Commercial

**ORDERING/ATTENDING PROVIDER**

Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**SERVICING FACILITY/VENDOR**

Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Requested Start Date of Service: \_\_\_\_\_

HCPCS J Code (s): \_\_\_\_\_ ICD10 Diagnosis Code(s): \_\_\_\_\_

***Please answer the following clinical questions:***

What type of cancer does the member have (include histology) and what stage disease?

\_\_\_\_\_

What is the member's chemotherapy regimen? \_\_\_\_\_

What line of therapy is this considered (First, Second, Subsequent)? \_\_\_\_\_

What previous therapies has the member received? (Include if the member progressed or relapsed): \_\_\_\_\_

\_\_\_\_\_

**Please attach all pertinent clinical information**

Attached:

☐

YES

☐

NO

**\*\*Please verify member's eligibility and benefits through the health plan\*\***

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