



**Outpatient Chemotherapy  
Chemotherapy Request Form  
Fax to 833-619-5745  
(Medical Benefit Only)**

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

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

Member UMI: \_\_\_\_\_  Medicare  Commercial

Requesting Physician's Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Requesting Physician's Address: \_\_\_\_\_

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

Facility: \_\_\_\_\_ Facility NPI Number: \_\_\_\_\_

Facility's Address: \_\_\_\_\_

Date of Service: \_\_\_\_\_

J Code (s): \_\_\_\_\_

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? (Please 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\*\***

Fax this completed form to Highmark at 1-833-619-5745