Outpatient Chemotherapy Preauthorization Form

Please complete this form in its entirety. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained from Avera Health Plans. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: ______________________________ Date of Birth: ____________________

Member ID Number: ______________________________ Group Number: ____________________

ICD code(s), please list all that apply: ______________________________

Where will chemotherapy be given? ______________________________

Please complete the following:

Chemotherapy protocol (i.e. R-CHOP): ____________ Chemotherapy Start Date: ____________________

Number of chemotherapy cycles requested: ____________ Each chemotherapy cycle lasts how many days? ____________

Chemotherapy Agent	HCPCS	Dose & Schedule

Previous Chemotherapy Protocols tried, if applicable (doses & dates not needed):

____

Is the requested chemotherapy protocol recognized by NCCN? ☐ Yes ☐ No

If not, please explain and provide supporting clinical documentation: ______________________________

____

Determination of medical necessity requires the submission of documentation.

☐ Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records: ______________________________

☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Prescriber Name: ____________________ Today's Date: ____________________

Person completing the form: ____________________ Your Office/Facility Name: ____________________

Your Phone Number: (_____) ____________________ Your Fax Number: (_____) ____________________

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim to DAKOTACARE. If you have questions about your benefits, please contact DAKOTACARE Service Center at 605-334-4000 or toll-free at 1-800-658-5508. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to DAKOTACARE at **1-605-274-3279** or send a secure email to Pharmacy@DAKOTACARE.com.