

Physician Chemotherapy Drug Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6038** or urgent requests to **866-533-5491**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call 866-533-5490. *Form must be completed for processing.*



Patient Name: _____ Plan ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg Birth Date: _____

Physician Name: _____ NPI #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

Drug to be administered from (on): _____ to _____
 Diagnosis: _____ ICD-9 Diagnosis Code: _____

Please indicate the applicable process:

- The medication will be acquired by the physicians' office, hospital or long-term care facility and billed directly to the plan by that physician or facility.
- A local, long term care, or specialty pharmacy will provide the medication and bill the plan.

**Justification for Request for IV 5-HT₃ receptor antagonists instead of ORAL 5-HT₃ (Add attachment if necessary) _____

Deliver to: Physician's Office Patient's Address Other Location: _____
 Physician Signature: _____ Date: _____

Premedications	Doxorubicin	mg IV Q	X	Day(s) or Dose(s)
Cimetidine mg IV Q X Day(s) or Dose(s)	Etoposide	mg IV Q	X	Day(s) or Dose(s)
Dexamethasone mg IV Q X Day(s) or Dose(s)	Fludarabine	mg IV Q	X	Day(s) or Dose(s)
Diphenhydramine mg IV Q X Day(s) or Dose(s)	Fluorouracil	mg IV Q	X	Day(s) or Dose(s)
Ranitidine mg IV Q X Day(s) or Dose(s)	Gemcitabine	mg IV Q	X	Day(s) or Dose(s)
Antiemetics	Ifosfamide	mg IV Q	X	Day(s) or Dose(s)
Dolasetron mg IV Q X Day(s) or Dose(s)	Irinotecan	mg IV Q	X	Day(s) or Dose(s)
Metoclopramide mg IV Q X Day(s) or Dose(s)	Methotrexate	mg IV Q	X	Day(s) or Dose(s)
Ondansetron mg IV Q X Day(s) or Dose(s)	Mitomycin	mg IV Q	X	Day(s) or Dose(s)
Prochlorperazine mg IV Q X Day(s) or Dose(s)	Mitoxantrone	mg IV Q	X	Day(s) or Dose(s)
Chemotherapy/Adjuvant Agents	Paclitaxel	mg IV Q	X	Day(s) or Dose(s)
Amifostine mg IV Q X Day(s) or Dose(s)	Pamidronate	mg IV Q	X	Day(s) or Dose(s)
Bleomycin mg IV Q X Day(s) or Dose(s)	Rituximab	mg IV Q	X	Day(s) or Dose(s)
Carboplatin mg IV Q X Day(s) or Dose(s)	Thiotepa	mg IV Q	X	Day(s) or Dose(s)
Carmustine mg IV Q X Day(s) or Dose(s)	Topotecan	mg IV Q	X	Day(s) or Dose(s)
Cisplatin mg IV Q X Day(s) or Dose(s)	Vinblastine	mg IV Q	X	Day(s) or Dose(s)
Cyclophosphamide mg IV Q X Day(s) or Dose(s)	Vincristine	mg IV Q	X	Day(s) or Dose(s)
Cytarabine mg IV Q X Day(s) or Dose(s)	Vinorelbine	mg IV Q	X	Day(s) or Dose(s)
Dacarbazine mg IV Q X Day(s) or Dose(s)	Interferons			
Docetaxel mg IV Q X Day(s) or Dose(s)	Interferon alfacon-1	µg SCQ	Day(s) or times weekly	X Weeks
	Interferon alfa-2A	IU SCQ	Day(s) or times weekly	X Weeks
Other/Hydration:				

All medications must be requested monthly.