



Send completed form to:  
**Peach State Health Plan Pharmacy Department**  
**Fax: 1-866-374-1579**

## Hycamtin

### Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_

1. What drug is being prescribed?  Hycamtin  Other \_\_\_\_\_
2. What is the diagnosis?  Relapsed small cell lung cancer  Other \_\_\_\_\_
3. **What is the ICD9?** \_\_\_\_\_
4. Is the patient currently receiving Hycamtin capsule therapy?  Yes  No *\*If No, Skip to #6*
5. Will complete blood counts be monitored frequently throughout therapy?  Yes  No
6. What is the patient's gender?  Female  Male *\*If Male, Skip to #10*
7. Is the patient currently pregnant or breastfeeding?  Yes  No
8. Is the patient of childbearing potential?  Yes  No *\*If No, Skip to #10*
9. Was the patient advised of the importance of not conceiving a child and not breastfeeding with Hycamtin therapy?  Yes  No
10. Did the patient have a complete response or partial response to first-line chemotherapy?  Yes  No
11. Has it been **AT LEAST** 45 days from the end of first-line chemotherapy?  Yes  No
12. Document BASELINE platelet count: \_\_\_\_\_ **cells/mm<sup>3</sup>**
13. Document BASELINE neutrophil count: \_\_\_\_\_ **cells/mm<sup>3</sup>**

**Information given on this form is accurate as of this date:**

**X** \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

**\*\*NOTE: We can NOT make a decision without a copy of lab results - Thank You\*\***

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