



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

## Oforta

### 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 copay 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?  Oforta  Other \_\_\_\_\_
2. What is the diagnosis?  Chronic Lymphocytic Leukemia (CLL)  Other \_\_\_\_\_
3. **What is the ICD9?** \_\_\_\_\_
4. Is the patient an adult (18 years of age or older)?  Yes  No
5. Has the patient not responded to or experienced disease progression during or after an alkylating agent-containing regimen?  Yes  No
6. Will the patient receive Nipent (pentostatin) concurrently with Oforta tablets?  Yes  No
7. Is the patient currently receiving Oforta tablets?  Yes  No *\*If No, no further questions*
8. Is the patient exhibiting signs or symptoms consistent with neurotoxicity or autoimmune hemolytic anemia?  Yes  No
9. Is the patient continuing to benefit from Oforta tablets therapy?  Yes  No

*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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