

Today's Date: _____

Office Administered Chemotherapy Coverage Determination Form

Please fax to PerformRx at 855-811-9332 or to speak to a representative call 888-602-3741

Form must be completed for processing

Please Attach Any Needed Documentation

Patient Name: _____ Member ID#: _____ Address: _____ City: _____ State: _____ Zip: _____ DOB: ____ / ____ / ____ Height _____ Phone _____ BSA: _____ Weight _____ Primary ICD-10 code: Diagnosis _____ Specific Therapy Regimen (ex. FOLFOX): _____ Additional Information: _____	Prescriber Name: _____ NPI: Practice Name: _____ Provider ID# Address: _____ City: _____ State: _____ Zip: _____ Contact Name: _____ Phone: _____ Fax: _____ Prescriber Signature: _____ Date: _____ ...
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Premedications	STRENGTH /FREQUENCY	DATE OF SERVICE	Chemotherapy/Adjuvant Agents	STRENGTH /FREQUENCY	DATE OF SERVICE
cimetidine			Erbitux [®]		
ranitidine			Etopophos [®] (etoposide phosphate)		
Antiemetics			etoposide		
Aloxi [®]			fluorouracil		
Anzemet [®]			Gemzar [®]		
granisetron			Herceptin [®]		
ondansetron			Hycamtin [®]		
diphenhydramine			ifosfamide		
dexamethasone			irinotecan		
Chemotherapy/Adjuvant Agents			leucovorin		
Abraxane [®]			methotrexate		
amifostine			mitomycin		
Avastin [®]			paclitaxel		
bleomycin			pamidronate		
carboplatin			oxaliplatin		
cisplatin			Rituxan [®]		
cyclophosphamide			Taxotere [®]		
cytarabine			vinblastine		
dacarbazine			vincristine		
Doxil [®]			vinorelbine		
doxorubicin hcl			Zometa [®]		
HYDRATION:			OTHER:		
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Please complete the specific authorization forms for ESA's and/or White Blood Cell Stimulators*