

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.  
Allow at least 24 hours for review.**

**Section A – Member Information**

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

**Section B - Provider Information**

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

**Section C - Medical Information**

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

**Section D – Previous Medication Trials**

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the medication being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?</b> <i>If yes, list supported use:</i>
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**ARIMIDEX**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is anastrozole being requested for <u>one</u> of the following?</b> <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adjuvant treatment of a postmenopausal patient with hormone receptor-positive early breast cancer</li> <li><input type="checkbox"/> First-line treatment of a postmenopausal patient with hormone receptor-positive or hormone receptor status unknown locally advanced or metastatic breast cancer</li> <li><input type="checkbox"/> Postmenopausal patient with disease progression following tamoxifen therapy</li> </ul>
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**AROMASIN**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is exemestane being requested for <u>one</u> of the following?</b> <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adjuvant treatment of a postmenopausal patient with estrogen receptor-positive early breast cancer who has received 2 to 3 years of tamoxifen and is switched to exemestane for completion of a total of 5 consecutive years of adjuvant hormonal therapy</li> <li><input type="checkbox"/> Treatment of advanced breast cancer in a postmenopausal patient whose disease has progressed following tamoxifen therapy</li> </ul>
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**FARESTON**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is Fareston being requested for the treatment of metastatic breast cancer in a postmenopausal patient with estrogen receptor positive tumors or with tumors of unknown estrogen receptor status?</b>
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**CONTINUATION OF THERAPY**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a documented positive clinical response to therapy?</b> <i>If yes, list response:</i>
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**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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