



**Oforta<sup>®</sup> Prior Authorization Request Form**

**Please fax the completed request form to Mercy Health Plans Pharmacy Department at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient Pharmacy ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (located on bottom right of insurance card)  
 Requesting Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 (Please print)  
 Office Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ ext \_\_\_\_  
 Office Address: \_\_\_\_\_  
 Medication/dose Requested: \_\_\_\_\_ Fax #: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
 Expected Duration of Therapy: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Please circle YES or NO:

1. Does the patient have a diagnosis of B-cell chronic lymphocytic leukemia (CLL)? YES NO  
 Has the patient demonstrated treatment failure with a chemotherapy regimen that contains a first-line alkylating agent (e.g., chlorambucil [PO], bendamustine [IV], cyclophosphamide [IV/PO])? YES NO

If yes, please list regimen patient has tried, below.

Chemotherapy Regimen	Dose	Date	Therapeutic Outcome

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Mercy Health Plans use only:**

Approved Length of Approval \_\_\_\_\_  
 Denied Reason for Denial \_\_\_\_\_  
 Reviewer's Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Override Entered in  Caremark  CCMS for \_\_\_\_\_ - \_\_\_\_\_ by \_\_\_\_\_  
 Office Notified on \_\_\_\_\_; at \_\_\_\_\_ am/pm; by \_\_\_\_\_ spoke to \_\_\_\_\_