carelon Rx

Prior Authorization Request

Breast Cancer Prevention

Patient Information

Patient Name:____

ID #: ___________________

DOB: _____/_____/_______

Provider Information

Name: ____

Address: ____

____

____

Phone: (_____)______-_____________

Drug Requested: ☐ Anastrozole ☐ Exemestane ☐ Letrozole ☐ Raloxifene ☐ Soltamox ☐ Tamoxifen

Please answer the following questions:

1. ☐ Yes ☐ No Is this medication being prescribed to a woman aged ≥ 35 years who is at increased risk for breast cancer, including women with previous benign breast lesions on biopsy (such as atypical ductal or lobular hyperplasia and lobular carcinoma in situ), and/or other risk factors (e.g. BRCA 1/2, history of chest radiation therapy, family history of breast cancer)?

2. ☐ Yes ☐ No Is this medication being prescribed to a woman who has a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS)?

3. ☐ Yes ☐ No If the requested medication is **Raloxifene**, is the patient post-menopausal?

4. ☐ Yes ☐ No If the requested medication is **Soltamox**, is the patient unable to swallow or does the patient have difficulty in swallowing tamoxifen tablets?

Please document the diagnoses, symptoms, and/or any other information important to this review:

____

____

____

Signature of Physician

Signature of Physician: ________________________________ Date: _____/_____/_______

Complete form and fax to 844-462-5169. Please do not include a cover sheet.

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