

State of Oklahoma SoonerCare Azedra[®] (lobenguane I-131) Prior Authorization Form

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Member Name:					
Physician billing (HCPCS code:) Start Date (or date of next dose): Dose:	Member Name:	Date of Birth		Member ID#:	
Dose:	Drug Information				
Dose:	Physician billing (HCPCS code:) Start Date (or date of next dose):				
Billing Provider Information Provider Name: Provider Phone: Provider Fax: Prescriber Information Prescriber Phone: Prescriber Fax: Specialty: Criteria For Initial Authorization: 1. Is diagnosis unresectable, locally advanced, or metastatic pheochromocytoma or paraganglioma, please indicate diagnosis: Additional Information: 2. Does member require systemic anticancer therapy? Yes No 3. Idst of last dose:					
Provider NPI: Provider Name: Provider Phone: Prescriber Information Prescriber NPI: Prescriber Name: Prescriber Phone: Prescriber Fax:					
Provider Phone: Prescriber Information Prescriber NPI: Prescriber Name: Prescriber Phone: Prescriber Fax: Specialty: Critoria For Initial Authorization: Critoria 1. Is diagnosis unresectable, locally advanced, or metastatic pheochromocytoma or paraganglioma? Yes Yes No 2. Does member require systemic anticancer therapy? Yes No 3. lobenguane scan positive? Yes No 4. If diagnosis is NOT unresectable, locally advanced, or metastatic pheochromocytoma or paraganglioma, please indicate diagnosis: Additional Information:		-			
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