MC-Rx
Powered by ProCare Rx

Cytoxan® cyclophosphamide

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Cytoxan®** cyclophosphamide. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information		
Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: check all that apply)

1. Please indicate type of cancer being treated: ☐ ICD-9 code ☐ ICD-10 code _____

   ☐ Multiple myeloma
   ☐ Malignant lymphomas
   ☐ Adenocarcinoma of the ovary
   ☐ Retinoblastoma
   ☐ Breast cancer
   ☐ Neuroblastoma
   ☐ Other: _____

2. Please indicate chemotherapy regimen: _____

3. If medication is not being used to treat cancer, please indicate reason for use:

   _____

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.