Wellpoint

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. Please do not include a cover sheet.

	Exchange
Maryland	877-671-6773
Texas	877-671-6775
Florida	877-671-6721