

**Physician's Prior Authorization Questionnaire
Oforta™**

Patient:

ID#:

DOB:

Patient Address:

Oforta™ is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. Does the patient have a diagnosis of B-cell Chronic Lymphocytic Leukemia? Yes No
2. Has the cancer progressed or been non responsive to previous treatment? Yes No
3. If the patient does not have B-cell Chronic Lymphocytic Leukemia, what is the diagnosis? (*Please do not use codes.*)

Oforta™ will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number / Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx