



Chemotherapy/Injectable Prior Authorization Information Request

Instructions: Please fax this completed form, along with the Prior Authorization Form/TAR, to the **Alliance Pharmacy Department at (831) 430 5851**. Please include copies of all relevant chart notes and laboratory results.



Name	DOB	ID#	
DIAGNOSIS	DATE OF DIAGNOSIS	MALE/FEMALE	
HEIGHT	WEIGHT	BSA	
CHEMOTHERAPY REGIMEN			
MEDICATION	STRENGTH	TARGET DOSE	# CYCLES

PLEASE INCLUDE RELEVANT LABS

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