# 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**

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

www.thealliance.health

06-2021