

**Pre-Service/Prior Authorization
Review Request for Infusion Drugs**
Request Date: _____

Complete and fax to:
800-843-1114
**(Handwritten faxes
not accepted.)**



MEMBER/PATIENT: _____ Date of birth: _____
Member ID: _____ Suffix: _____ Group #: _____

<p>REQUESTING PROVIDER: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required): _____ NPI # (required): _____</p>	<p>SERVICING PROVIDER: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required): _____ NPI # (required): _____</p>
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REQUIRED: Complete all fields that apply for place of service. To enable site of service boxes, download form before completing.

<p>FACILITY: _____ Address: _____ City: _____ State: _____ ZIP: _____ Tax ID (required): _____ NPI # (required): _____ Phone: _____ Fax: _____</p>	<p><input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Ongoing treatment Other _____ Date scheduled: _____ Existing reference #: _____ Expiration date: _____</p>
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URGENT REQUEST
PLEASE NOTE: Scheduling issues do not meet the definition of urgent.
Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, or
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: _____

Procedure code/CPT code:	ICD diagnosis code:

REQUIRED: *For OP hospital infusion: Criteria for exceptions includes the list below. Select criteria and attach supporting medical records, include presenting symptoms and previous treatment.

<p><input type="checkbox"/> Clinical condition present that increases the risk of an adverse reaction</p> <p><input type="checkbox"/> Unstable renal function</p> <p><input type="checkbox"/> History of difficult vascular access</p> <p><input type="checkbox"/> Acute mental status changes/cognitive conditions that affect the safety of infusion therapy</p>	<p><input type="checkbox"/> First-time infusion</p> <p><input type="checkbox"/> Re-initiation after more than six months</p> <p><input type="checkbox"/> History of severe adverse drug reactions and/or anaphylaxis to prior or similar treatment</p> <p><input type="checkbox"/> Access greater than 50 miles from patient's home</p> <p><input type="checkbox"/> OP hospital is the only infusion option available</p>
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Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA. **Confidentiality notice:** The information contained in this facsimile message is privileged or confidential, and intended only for the individual or entity named above. If the reader is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us at 877-342-5258.