

**PRE-SERVICE/PRIOR
AUTHORIZATION REVIEW
REQUEST FOR INFUSION DRUGS**

Fax to Care Management:
800-843-1114



Request date _____

URGENT – Urgent requests must 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, in the opinion of a provider with knowledge of the member's medical condition, subject the patient to severe pain that they can't adequately manage without requesting care or treatment.

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

REQUESTING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact Person: _____ Tax ID (REQUIRED): _____ NPI # (If available): _____	SERVICING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact Person: _____ Tax ID (REQUIRED): _____ NPI # (If available): _____
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REQUIRED: Complete all fields that apply for place of service.

FACILITY: _____ Address: _____ City/State/ZIP: _____ Tax ID (REQUIRED): _____ NPI # (If available): _____ Phone: _____ Fax: _____	<input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Office / Ambulatory Surgical Center <input type="checkbox"/> Home <input type="checkbox"/> Ongoing treatment Date scheduled: _____ Existing reference #: _____ Expiration date: _____
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REQUIRED: Procedure/CPT code	ICD 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.

<input type="checkbox"/> Clinical condition present that increases the risk of an adverse reaction <input type="checkbox"/> Unstable renal function <input type="checkbox"/> History of difficult vascular access <input type="checkbox"/> Acute mental status changes/cognitive conditions that affect the safety of infusion therapy	<input type="checkbox"/> First-time infusion <input type="checkbox"/> Re-initiation after more than six months <input type="checkbox"/> History of severe adverse drug reactions and/or anaphylaxis to prior or similar treatment <input type="checkbox"/> Access greater than 50 miles from patient’s home <input type="checkbox"/> OP hospital is the only infusion option available
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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.
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