PRE-SERVICE/PRIOR AUTHORIZATION REVIEW REQUEST FOR INFUSION DRUGS

Request Date _____

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

PREMERA | BLUE CROSS

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

REQUESTING PROVIDER: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
Contact person: _____
Tax ID (**required**):_____
NPI # (**required**): _____

SERVICING PROVIDER: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
Contact person: _____
Tax ID (**required**):_____
NPI # (**required**): _____

REQUIRED: Complete all fields that apply for place of service. To enable SOS boxes download form before completing

FACILITY: _____
Address: _____
City: _____ State: _____ ZIP: _____
Tax ID (**required**):_____
NPI # (**required**): _____
Phone: _____ Fax: _____

☐ Outpatient hospital ☐ Inpatient hospital
☐ Office ☐ Home
☐ Ongoing treatment Other _____
Date scheduled: _____
Existing reference #: _____
Expiration date: _____

☐ **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.

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

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.