IMPORTANT INSTRUCTIONS PLEASE DOWNLOAD THIS FORM

Please note we will only be accepting electronic and not handwritten forms starting 6/1/2021. For faster and more efficient processing please submit via the online portal.

We are asking Providers to use our online tools for the following requests. Please check codes online to confirm a review is required before submitting a prior authorization request. This will help ensure we are able to get to qualifying requests in a timely manner. We also encourage you to submit your Prior Authorization Request on the Portal for faster processing.

- Patient Eligibility
- Prior Authorization Code Checks
- Prior Authorizations
- Status checks, even if faxed prior (for in area providers only)

A screenshot with the date included of the information found online can be used for verification documentation in the event you need to appeal.

For providers in Washington, Alaska:

Check it out today at: WA: premera.com/wa/provider/utilization-review/about-prior-authorization/ AK: premera.com/ak/provider/utilization-review/about-prior-authorization/

For providers outside of Washington, Alaska:
Visit your local Blue plan's provider website or go to:
WA: premera.com/wa/provider/outside-washington-alaska/
AK: premera.com/ak/provider/outside-washington-alaska/

PRE-SERVICE/PRIOR AUTHORIZATION REVIEW REQUEST FOR INFUSION DRUGS

Fax to Care Management:
800-843-1114

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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: _____	**SERVICING PROVIDER:** _____
Address: _____	Address: _____
City/State/ZIP: _____	City/State/ZIP: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Contact Person: _____	Contact Person: _____
Tax ID (REQUIRED): _____	Tax ID (REQUIRED): _____
NPI # (If available): _____	NPI # (If available): _____

REQUIRED: Complete all fields that apply for place of service.

FACILITY: _____	☐ Outpatient hospital
Address: _____	☐ Inpatient hospital
City/State/ZIP: _____	☐ Office / Ambulatory Surgical Center
Tax ID (REQUIRED): _____	☐ Home
NPI # (If available): _____	☐ Ongoing treatment
Phone: _____ Fax: _____	**Date scheduled:** _____
	Existing reference #: _____
	Expiration date: _____

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.

☐ Clinical condition present that increases the risk of an adverse reaction	☐ First-time infusion
☐ Unstable renal function	☐ Re-initiation after more than six months
☐ History of difficult vascular access	☐ History of severe adverse drug reactions and/or anaphylaxis to prior or similar treatment
☐ Acute mental status changes/cognitive conditions that affect the safety of infusion therapy	☐ 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.