PRE-SERVICE/PRIOR AUTHORIZATION REVIEW REQUEST FOR INFUSION DRUGS

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

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Request Date

MEMBER/PATIENT: _____ 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 # (**required**): _____	NPI # (**required**): _____

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

FACILITY: _____	☐ Outpatient hospital ☐ Inpatient hospital
Address: _____	☐ Office ☐ Home
City: _____ State: _____ ZIP: _____	☐ Ongoing treatment Other _____
Tax ID (**required**): _____	**Date scheduled:** _____
NPI # (**required**): _____	**Existing reference #:** _____
Phone: _____ Fax: _____	**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.

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