

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

Complete and fax to:
800-704-2901
**(Handwritten faxes not
accepted.)**



Request Date _____

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): _____
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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: _____	<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: _____
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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.

<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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