PREMERA HMO

Pre-service/Prior Authorization Review Request for Infusion Drugs

Instructions

- **This form must NOT be handwritten.**
- Download this form to complete it. For expedited response, please use the Availity site for authorization requests (not available for FEP).
- Use the following numbers for faxing. This form must be the first two pages of the fax submission.
  - PBC fax: 800-843-1114
  - FEP fax: 866-948-8823

A. Member/patient information

Member/patient name			Date of birth
Member ID Number Details	Alpha prefix	ID Number	Suffix

B. Urgent request: Note scheduling issues do not meet the definition of urgent.

☐ Check this box if this is an urgent request.

Urgent requests **must be signed by the requesting provider** and include supporting documentation from the provider's office, Services more than five days out are not considered urgent. Note: 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.

MD Signature: **I attest that this request meets the urgent definition described above.**	Print name	
X _____	Print title	Date signed

C. Provider information: Every field in this section is required.

Name of requesting provider		Contact person	
Address	City	State	ZIP code
Phone number with area code		Fax number with area code	
Tax ID		NPI number	

Is the servicing provider the same as the requesting provider?

❍ Yes. Skip to section D.

❍ No. Continue with servicing provider information below. This information is required.

Name of servicing provider		Contact person	
Address	City	State	ZIP code
Phone number with area code		Fax number with area code	
Tax ID:		NPI number	

D. Facility information

Select the type of facility
❍ Outpatient hospital
❍ Inpatient hospital
❍ Freestanding infusion center
❍ Home
❍ Office
❍ Other: _____

Name of facility	Contact person		
Address	City	State	ZIP code
Phone number with area code	Fax number with area code		
Tax ID (required):	NPI # (required)		

E. Clinical information

Date scheduled	Existing reference number	Expiration date

Procedure code/CPT code:	ICD diagnosis code:

Required: *For outpatient 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 risk of an adverse reaction	☐ First-time infusion
☐ Unstable renal function	☐ Re-initiation after more than six months
☐ History of vascular access issues	☐ 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
	☐ Outpatient 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.

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