PRIOR AUTHORIZATION REQUEST - INJECTABLE MEDICATION

TO BE ADMINISTERED AT DOCTOR'S OFFICE

Please complete all applicable fields in this form. Fax the completed form to Pharmacy Services at 877-232-5976.

PATIENT INFORMATION

Patient name:	Patient ID:
Date of birth (MM/DD/YY):	Gender: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Physician name:

Specialty:

Phone:	Fax:

Contact person:

AUTHORIZATION INFORMATION

Diagnosis:	Diagnosis code:

Referring physician:

Who is administering?	Location of administration:

Medication and dose requested	Start/end dates of service		J-Code/HCPCS codes*	Number of visits

MEDICAL RATIONALE FOR USE**

SPECIAL CONSIDERATIONS (This form should only be used for requests for injectable medications that will be administered in office by a HCP (buy-and-bill). Do not use this form if the patient will receive medication for self-administration at home.)

Prescriber Signature Date

*Please ensure that the correct J-Code is used. This will expedite processing for your request.

**If medication/therapy prescribed requires prior authorization, provide rationale for use. Please include pertinent patient visit notes and/or labs to avoid delays in processing.