



HIGHMARK
NORTHEASTERN NEW YORK

Medical Specialty Drug Authorization Request Form

Please print, type or write legibly in blue or black ink. **Once completed, please fax this form to the designated fax number for medical injectables at 833-619-5745.** Authorization requests may alternatively be submitted via phone by calling 1-800-452-8507 (option 3, option 2).

*Please note this form does **NOT** represent a legal prescription order, and the official prescription order/referral must be sent to the servicing pharmacy provider.

REQUEST TYPE				
Initial Request <input type="checkbox"/> Expedited Request <input type="checkbox"/> Standard Request		Appeal <input type="checkbox"/> Peer to Peer <input type="checkbox"/> Expedited Appeal <input type="checkbox"/> Standard Appeal		
MEMBER INFORMATION				
Member ID Number		Group Number (If Available)	<input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> Member is under 21 years of age and is considered medically fragile
Member Name		Member DOB	Member Phone Number	
Member Address		City	State	Zip Code
DRUG INFORMATION				
Diagnosis Code (ICD-10)	Diagnosis Code Description			
HCPCS Code (J-Code)	Requested Drug Name	Drug Strength or Dose	Quantity (# of doses/visits)	
Directions		Requested Start Date of Service		
MEDICAL RATIONALE / REASON FOR DRUG THERAPY / TREATMENT PLAN <i>(please include supporting clinical information in your request)</i>				
SITE OF CARE				
Place of Administration Name	NPI	Phone	Ext.	Fax
Servicing Provider Address	City	State	Zip Code	
Place of Administration Type <i>(please select one)</i> <input type="checkbox"/> Home Infusion (12) <input type="checkbox"/> Office – Professional (11) <input type="checkbox"/> Ambulatory Infusion Suite – Professional (49) <input type="checkbox"/> Outpatient Hospital (22) Is the site of care affiliated with a hospital or will the claim be billed as a facility claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Drug Dispensing Information <i>(please select one)</i> <input type="checkbox"/> Supplied by a Specialty Pharmacy <i>(for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional)</i> Name of Specialty Pharmacy: _____ NPI: _____ <input type="checkbox"/> Buy & Bill <i>(for Office – Professional or Outpatient Hospital administration)</i> Ship To <i>(please select one)</i> <input type="checkbox"/> Physician’s Office <input type="checkbox"/> Member’s Home <input type="checkbox"/> Other _____				
REQUESTING PHYSICIAN INFORMATION <i>(Required for mailing notification – Please print legibly)</i>				
Physician Name	NPI	Phone	Ext.	Fax
Physician Address	City	State	Zip Code	
Physician Signature (REQUIRED)		DEA <i>(if applicable)</i>	Date	
Contact Name		Contact Phone	Ext.	