




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 833-581-1861.** 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.**

MEMBER INFORMATION				
Member ID Number	Group Number (If Available)			
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 (please include supporting clinical information in your request)				
SITE OF CARE				
Place of Service (please select one)				
<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				
Place of Service Name	NPI	Tax ID	Phone	Ext. Fax
Place of Service Address	City	State	Zip Code	
Drug Supplier Information (please select one)				
<input type="checkbox"/> Supplied by a Specialty Pharmacy (for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional) Name of Specialty Pharmacy: _____ NPI: _____				
<input type="checkbox"/> Buy & Bill (for Office – Professional or Outpatient Hospital administration)				
Ship To (please select one)				
<input type="checkbox"/> Physician’s Office <input type="checkbox"/> Member’s Home <input type="checkbox"/> Other _____				
ORDERING/ATTENDING PROVIDER INFORMATION (Required for mailing notification – Please print legibly)				
Physician Name	NPI	Phone	Ext.	Fax
Physician Address	City	State	Zip Code	
Physician Signature (REQUIRED)		DEA (if applicable)	Date	
Contact Name	Contact Phone Ext.			
REQUEST TYPE				
Initial Request	Appeal			
<input type="checkbox"/> Expedited Request <input type="checkbox"/> Standard Request	<input type="checkbox"/> Peer to Peer <input type="checkbox"/> Expedited Appeal <input type="checkbox"/> Standard Appeal			

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