

INJECTABLE INFUSION FORM

Medicare Part D: Fax to **(855) 714-6218** Pharmacy Request

Requested by: Physician Member

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Please Check One (Not checking a box will indicate a Standard Review.)

REQUEST FOR EXPEDITED REVIEW

By checking the Expedited Review box, the requestor certifies that applying the Standard Review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results).		Date of Request:	
Member ID #:		Provider ID #:	
Member Name:		Physician NPI:	
Member's Date of Birth:		Physician Name:	
Member Phone:		Contact Name at MD Office:	
Diagnosis of Requested Medication:		Physician Phone:	
Height:	Weight (lb/kg):	Physician Fax:	
Allergies:		Pharmacy Phone:	Pharmacy Fax:
Requested Medication Name	Dose	Frequency	Length of Treatment
<i>(Please use another form if more lines are needed.)</i> Physician Signature:			
Document clinical rationale for request. List all names and doses of previous medication(s) tried and failed. Include all supporting documentation.			
<p>1. Is the medication being supplied and administered in physician's office? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Will the medication be sent to the provider's office for administration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes: Pharmacy is responsible for collecting the medication co-payment from the patient.</p> <p>3. Is the medication being administered at a facility or outpatient center? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Facility Name/Outpatient Clinic: _____</p> <p>Facility Name/Outpatient Clinic Provider ID #: _____</p> <p>Is the medication being administered at the patient's home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			