Healthcare Common Procedure Coding System (HCPCS) Authorization Form

Select Health of South Carolina

Healthy Connections

Confidential Information

Patient name:			
Patient date of birth (MM/DD/YYYY):		Patient ID number:	
Provider name:		Specialty:	
Phone:	Fax:	NPI:	
Provider street address:			
City:		State:	ZIP code:
Facility name:		Facility NPI:	
Medication name and strength requested:		J-code: Number of units: Date of service (MM/DD/YYYY):	
Directions:			

Anticipated length of therapy: ☐ Days ☐ 3 months ☐ 6 months

Treatment setting: ☐ Infusion center ☐ Home ☐ Provider's office ☐ Hospital outpatient facility

Diagnosis description & ICD-10 code:

Preferred medications tried/previous therapy — please include strength, frequency, and duration. (If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs.)

Rationale for hospital outpatient facility (if applicable):

- ☐ Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions.
- ☐ Documentation that the member is medically unstable for the safe and effective administration of the prescribed medication at an alternative site of care as a result of one of the following:
  - ☐ Complex medical condition, status, or therapy requires services beyond the capabilities of an office or home infusion setting (clinical instability or a complex regimen that requires frequent clinical assessment or monitoring, which would be beyond the capabilities of an office or home infusion setting).
  - ☐ Documented history of medical instability, significant comorbidity, or concerns regarding fluid status inhibits treatment at a less-intensive site of care (unstable fluid status associated with heart failure or advanced [stage 4 or 5] renal failure).
  - ☐ Clinically significant physical or cognitive impairment that precludes safe and effective treatment in an outpatient or home infusion setting (physical disability or disruptive or uncooperative behavior).
  - ☐ Difficulty establishing and maintaining reliable vascular access.

Rationale and/or additional information that may be relevant to the review of this prior authorization request. (If more space is needed, please attach an additional page to this document.)	
Provider signature:	Date (MM/DD/YYYY):

Please return this form via fax to: 1-866-610-2775
For questions, call: 1-866-610-2773

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