

# Healthcare Common Procedure Coding System (HCPCS) Authorization Form



## 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: <input type="checkbox"/> Days <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months		
Treatment setting: <input type="checkbox"/> Infusion center <input type="checkbox"/> Home <input type="checkbox"/> Provider's office <input type="checkbox"/> 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.)		
<p>Rationale for hospital outpatient facility (if applicable):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions.</li> <li><input type="checkbox"/> 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: <ul style="list-style-type: none"> <li><input type="checkbox"/> 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).</li> <li><input type="checkbox"/> 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).</li> <li><input type="checkbox"/> 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).</li> <li><input type="checkbox"/> Difficulty establishing and maintaining reliable vascular access.</li> </ul> </li> </ul>		

**Healthcare Common Procedure Coding System (HCPCS) Authorization Form**

---

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: 1-855-811-9332**  
**For questions, call 1-888-602-3741**

