Injectable/Infusible Medications Prior Authorization Request Form

Fax to PerformRx at, 855-829-2872 or to speak to a representative call.855-251-0966 ***Form must be completed for processing.***

Patient Name: _____ Patient ID #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Weight: _____ _____ lbs. = _____ _Kg Birth Date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____

Drug: _____ Dose: _____ Sig: _____

Diagnosis: _____ ICD-10 Diagnosis Code: _____

For coverage determination additional information is needed to proceed with review. Prior to receiving approval, the patient must have a documented medical reason to be unable to take therapeutic alternatives. Please identify the therapies attempted and document the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, and other medical reasons).

Drug	Dose	Start Date	End Date	Comments

Deliver to:

☐Member's Home ☐Physician's Office ☐Member's Preferred Pharmacy (Name/Phone#):_____

☐ I acknowledge that the member agrees with the pharmacy chosen for delivery of this medication.

Additional Comments: _____

_____

PERFORMRx