SPECIALTY MEDICATION REQUEST FORM

ALL REQUIRE MEDICAL RECORDS TO BE ATTACHED

Phone: (888) 796-0947
Fax: (888) 736-1123 or (813) 506-6226

INSTRUCTIONS

This form is for pre-certification **J** code requests under the Part B benefit (i.e. outpatient, in-office, or home health administration) and will be processed as quickly as possible depending on the member's health condition.

PLEASE FAX ALL SUPPORTING DOCUMENTATION: Clinical notes, laboratory results, creatinine clearance, cultures and sensitivities, etc.

IMMEDIATE OR EXPEDITED REQUESTS: Do not write STAT, ASAP or Immediate on this form. Please follow the instructions below. Medicare defines expedited as a request where "applying the standard time for making a determination could jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function."

ONLY COMPLETE THIS SECTION FOR EXPEDITED REQUESTS

If the PHYSICIAN feels the member meets this definition, please either:

1. Have the **PHYSICIAN *call* (888) 796-0947** to speak with our Medical Director to expedite your request, **or**
2. Have the **PHYSICIAN *document the reason he/she feels the member meets the Medicare definition of expedited.***

_____

_____

Date of Request:	**(Circle County)**	Citrus	Hillsborough	Manatee	Osceola	Polk	Sumter
	Brevard	Collier	Indian River	Marion	Palm Beach	Sarasota	Volusia
	Broward	Dade	Lake	Martin	Pasco	Seminole	
	Charlotte	Hernando	Lee	Orange	Pinellas	St. Lucie	

Member Information:

Member Name	
Member ID#	
Member Address	
City, State, Zip	
Phone	
DOB	
Ht/Wt (lb/kg)	
Allergies	
DX	

Requesting Office:

Provider (PCP) Name	
TIN# / NPI#	
Phone	
Fax	
Contact Person	

Ordering Physician:

Name	
TIN# / NPI#	
Phone	
Fax	

- **Requests for Procit, Epogen, and Aranesp REQUIRE laboratory results within 30 days prior to the request.**
- **Red Cell stimulators will be approved for 60 days then additional lab results are required.**
- **Iron requests REQUIRE iron panel (iron saturation %, Ferritin, TIBC) within 60 days.**

(Please use another form if more lines are needed)

HCPCS Code(s)	Medication	Dose	Start Date	Frequency	Length of Treatment

Signature of ordering physician: _____ ***Date:*** _____

Please answer all of the questions below for a thorough review.

1. Is the medication being administered in the physician's office? ❑ Yes ❑ No
   - Will the Physician "Buy and Bill" (Physician will be responsible to collect co-payment)? ❑ Yes ❑ No
   - Will medication be sent to the provider's office for administration (Pharmacy is responsible for collecting the medication co-payment)? ❑ Yes ❑ No

     Preferred Health Plan Pharmacy (Plan to select only): _____

     Phone Number: _____ Fax Number: _____
2. Is the medication being administered at a facility or outpatient center? ❑ Yes ❑ No

   (circle one) Facility/Outpatient Clinic Name/Skilled Nursing Facility Facility/Clinic Provider Name & ID#: _____
3. Is the medication being administered in patient's home? ❑ Yes ❑ No