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

Member Information:
Requesting Office:
Provider (PCP) Name
TIN# / NPI# Phone
Fax
Contact Person

Ordering Physician:
Name
TIN# / NPI# Phone
Fax

• Requests for Procrit, 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)

<table>
<thead>
<tr>
<th>HCPCS Code(s)</th>
<th>Medication</th>
<th>Dose</th>
<th>Start Date</th>
<th>Frequency</th>
<th>Length of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Freedom/Optimum Specialty Medication Request Form 2022
www.freedomhealth.com www.youroptimumhealthcare.com