Home Infusion Therapy Prior Authorization Form

Please complete and fax with the physician's prescription to: (888) 641-5355. If the patient is a BCBSMA employee, please fax the form to: (617)246-4013. If the patient is a Blue MedicareRx member, please fax the request to Anthem Blue Cross Blue Shield at (866) 827-9822.

FOR TPN THERAPY, USE MEDICAL POLICY #296 REQUEST FORM

Company name:		Contact Name:			
Phone #:		Provider #:			
Fax#		Address:			
Patient name:		Address:			
Patient ID#:		DOB: / /	Diagnosis: (ICD-10)		
Prescribing Physician/addr:			Telephone:		
PCP name/address:			Telephone:		

Place of Service ☐ Home ☐ SNF ☐ MD office ☐ other (specify)

Primary Therapy

Primary drug name: Approximate duration: / / to ____/____/____
Dose: _____
Frequency: _____ Route of Administration: _____ pump: Y___ N___

Other Therapy

Other drug name:_____ Approximate duration: ____/____/____ to ____/____/____
Dose: _____
Frequency: _____ Route of Administration: _____ pump: Y___ N☐

☐ If this is a "drug only" authorization request, indicate other services the nursing agency is providing:

Nursing provided by: _____ Contact: _____
Phone: _____ Fax:_____

Request for 7 Day Coverage: Date of occurrence:_____ Request dates:_____
Occurrence type: ☐ Hospitalization ☐ Death ☐ Change of Therapy

Physician signature:_____ Date:_____

OR Copy of prescription REQUIRED with this request.