



# 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.**

<b>Date of Request:</b>	<b>(Circle County)</b>	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 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)

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
  - Does the office administering the medication need the medication shipped to them by the Plan's preferred pharmacy (pharmacy is responsible for collecting the medication co-payment)?  Yes  No
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