Capital

MEDICAL INJECTABLE DRUGS (NON-DRUG SPECIFIC)
PREAUTHORIZATION REQUEST
(PREAUTHORIZATION IS NOT A GUARANTEE OF PAYMENT)

SECTION I – General information

Today's date: / /	☐ New request
Fax completed form to: **866.805.4150 toll free.**	☐ Re-authorization

Level of urgency:

Standard request (routine care) - care/treatment that is not emergent, urgent, or preventive in nature.

Expedited request - care/treatment that is emergent or the application of the timeframe for making standard/routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state.
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For expedited request, please explain:

SECTION II – Member information

Patients name:	Member ID:	**Patient information**: DOB: __/__/__ Sex: Age: Weight: ☐ lbs. ☐ kg Will the patient self-administer the requested medication? ☐ Yes ☐ No
Patients address:	Is Capital Blue Cross primary payer: ☐ Yes ☐ No	

Plan type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP
☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at www.covermymeds.com/main or via phone at 866.260.0452.

SECTION III – Provider information required

Requesting provider name: **Address**:	**Requesting provider Capital #**_____ **NPI #** _____

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Telephone #:	Secure fax #:
Office contact name:	Office contact telephone #:

Is the rendering/servicing provider different?
☐ No ☐ Yes - Complete rendering provider information below.

Rendering provider name: **Address**: **Telephone:**	**Rendering provider Capital #**_____ **NPI #** _____

Site of service: ☐ MD office. ☐ Home health. ☐ Non-hospital affiliated, outpatient infusion center. ☐ Hospital affiliated, outpatient infusion center. ☐ Other: Specify. _____ **Please refer to MP 3.016 for site of service requirements.*	**Check all that apply and include all applicable documentation:** ☐ There are contraindications to a less intensive site of care. ☐ A less intensive site of care is not appropriate for the patient's condition. ☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. ☐ Less intensive site of care is not available. **Please include all applicable documentation.*

SECTION IV – Preauthorization requirements and clinical criteria

Prescribed in consultation with a specialist? ☐ Yes Specialty: _____ ☐ No

☐ New to therapy. ☐ Continuing therapy*: Initial start __/__/__. ☐ Reinitiating therapy: Last treatment __/__/__. *Please include documentation for changes in dose.	**Route of administration:** ☐ Intravenous (IV). ☐ Injection (Sub Q or IM). ☐ Oral (PO) or Enteral. ☐ Other: Specify. _____
HCPCS code(s):	**Diagnosis code(s)**:
Medication requested:	**Indication:**

Does the patient have late-stage metastatic disease? ☐ Yes ☐ No
For patients with late-stage metastatic disease (Stage IV), please refer to MP 2.373 Step Therapy Treatment in Cancer, Including Treatments for Stage Four, Advanced Metastatic Cancer and Severe Related Health Conditions for additional guidance.

Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐Other: Specify _____

Initial start date of therapy: __/__/__	Anticipated date of **next administration:** __/__/__

Dosing period for request: Start date: __/__/__ End date: __/__/__	**Dosing information:** Dose: Strength: Frequency: Quantity requested per month:

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Attach documentation demonstrating the medical necessity of the requested drug. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)

Has the patient had **medical testing** completed for use of this drug? (labs, imaging) ☐ Yes ☐ No

Results: _____

Is drug being requested for an "**off label" indication**? ☐ Yes ☐ No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

Please list any current medication(s) being used for treatment: Please attach documentation

Drug(s) and strength:

Is the prescriber a specialist in the area of the patient's diagnosis or has the prescriber has consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No

Please use a separate form for each drug.

To fill out form type or write using blue or black ink.

Please fax this form to: 866.805.4150.

Telephone: 800.471.2242.

Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.

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