PHYSICIAN ADMINISTERED OR INFUSION DRUG PRIOR AUTHORIZATION REQUEST FORM

Please fax this form along with supporting clinical documentation to the appropriate fax number below (corresponding to the service type).

Medicaid / Marketplace Exchange / Essential Plan / CHP / Gold / GoldCare / Medicare & UltraCare Step Therapy	Fax 212-908-5178

Authorization/Tracking #:	E-Power Cert #: (if applicable)

REQUEST TYPE

☐ **Preauthorization:** Request for approval for coverage of a service or treatment before the service or treatment is performed.

☐ **Retrospective:** Request for approval for coverage for a service or treatment already rendered without prior authorization.

Date(s) of Service: _____

☐ **Standard**
- Preauthorization = 3 business days
- Concurrent = 1 business day
- Retrospective = 30 calendar days

☐ **Expedited:** The expedited review request is subject to denial if there is no documented life-threatening condition or imminent danger to the member's health. If a request to expedite a review is denied, a determination will be made within the standard timeframe. Retrospective reviews are not eligible for expedited review.

MEMBER INFORMATION

Name:	ID#:	Date of Birth:
Street Address:		Phone Number:
ICD-10 Diagnosis Codes(s):		

PROVIDER INFORMATION

Requesting Provider Name:		Requesting Provider NPI:
Street Address:		
Phone Number:	Fax Number:	Contact Name:
Servicing Provider Name:		Servicing Provider TIN/NPI:
Street Address:		
Phone Number:	Fax Number:	Contact Name:

REQUESTED SERVICE INFORMATION

Code	Dose and Frequency	# of Doses	Date of Last Dose Given	Date of Next Scheduled Dose

PLACE OF SERVICE

☐ 11 Office ☐ 19 Off-Campus Outpatient ☐ 22 On Campus - Outpatient

☐ 12 Home ☐ Other _____