HIGHMARK HEALTH OPTIONS

INFUSION SITE OF CARE DRUG MANAGEMENT INFORMATION FORM

Please complete this **AND** appropriate Medication Prior Authorization form and fax to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Member ID:	

DRUG INFORMATION

Medication:	Route of Administration:
Directions/Frequency:	
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No	

PLACE OF SERVICE INFORMATION

Name:	NPI:
Address:	Phone:

Billing Information:

The medication will be billed:

☐ at a pharmacy (*for Home Infusion, Doctor's Office – professional billing, or Ambulatory Infusion Suite – Professional*)

☐ medically (*for Doctor's Office – professional billing or Outpatient Hospital Administration*), JCODE:_____

Will the drug be administered via home infusion or at the Doctor's office (professional billing only)? ☐ Yes ☐ No

- If no, which of the following, if any, apply to the member:
  - ☐ Member is initiating therapy
  - ☐ Member is re-initiating therapy after a period of 6 months with no therapy
  - ☐ Member had a previous reaction after administration
  - ☐ Member needs specific monitoring that is not routinely done by home infusion or at provider's office
  - ☐ Member is receiving other medications that require close monitoring (such as chemotherapy)
  - ☐ Member is at high risk of complications
  - ☐ Member's home is considered unsuitable for care (may be determined by the home infusion provider)
  - ☐ Member is physically and/or cognitively impaired and there is no caregiver available to comply with the treatment
  - ☐ No location available to provide the specific service
  - ☐ Other: _____

_____

Place of Service:

☐ Member's Home (billed via pharmacy or place of service code 12) **preferred*

☐ Doctor's Office – professional billing (place of service code 11) **preferred*

☐ Ambulatory Infusion Center (place of service code 49) **preferred*

OR

☐ Outpatient Hospital IV Infusion Department (place of service code 19)

☐ Hospital-based Outpatient Clinical Level of Care (place of service code 22)

Prescribing Provider Signature	Date