HIGHMARK Delaware
HEALTH OPTIONS

Home Infusion Request Form

Patient Name: _____

Member ID: _____ DOB: _____

Drug: _____ NDC: _____

DX Code: _____ Patient Height and Weight: _____

Dose and Frequency: _____

Admin Type (pump, gravity, injection, etc): _____

If being administered via pump, is the pump implanted or external?:

_____

Is the drug being obtained through a pharmacy or through the medical benefit (with J code, "buy and bill")?

_____

If being obtained through a pharmacy, what is pharmacy name and phone number?

_____

If being billed medically, what is the associated Jcode?

_____

Therapy Start Date: _____ Therapy End Date: _____

Prescriber's Full Name: _____

Prescriber's Phone: _____ Prescriber's Fax: _____

Prescriber's Address: _____

Contact Person: _____ Phone: _____

Prescriber's Signature: _____

Any questions, please call:
Highmark Health Options – 1-844-325-6251

Fax completed information to:
1-855-476-4158 (Highmark Health Options)

Updated 8/2019