PreferredOne®

Provider Administered Infusion/Injection Medication Authorization Form (Buy & Bill)

Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for Approval/Denial status of this request.

Attn: Pharmacy Dept. Fax (763.847.4014) **All fields required. Incomplete and/or Incorrect forms will be returned.**

EFFECTIVE 04/01/2019: NEW SITE OF CARE POLICY: MP/S014
PRIOR AUTHORIZATION FOR SITE OF CARE IN A HOSPITAL OUTPATIENT SETTING (19 or 22) MAY APPLY

LIST OF AFFECTED DRUGS: https://www.preferredone.com/shared/Phase1DrugList.pdf

POLICY LINK: https://www.preferredone.com/Shared/MedicalPolicy/MedicalPolicyActive/MP_S014.pdf

MEMBER INFORMATION

MEMBER NAME:			
MEMBER ID:	DATE OF BIRTH:	GENDER: ☐ M ☐ F ☐ O	
ADDRESS:	CITY:	STATE:	ZIP:

PROVIDER INFORMATION

PROVIDER NAME: *(FIRST & LAST)*		NPI NUMBER:	SPECIALTY:
CLINIC NAME:	CONTACT: *(NAME & PHONE)*	SECURE FAX/EMAIL:	
ADDRESS:	CITY:	STATE:	ZIP:

SITE OF CARE (SERVICING PROVIDER)

*SEE ABOVE LINK FOR DRUGS SUBJECT TO SITE OF CARE PRIOR AUTHORIZATION

SITE OF CARE: ☐ CLINIC/OFFICE (11) ☐ HOME (12) ☐ *OUTPATIENT HOSPITAL (19 OR 22)

NAME:		NPI NUMBER:	
CONTACT: *(NAME & PHONE)*	SECURE FAX/EMAIL:		
ADDRESS:	CITY:	STATE:	ZIP:

MEDICATION REQUESTED

SITE OF CARE EXCEPTION REQUESTS: PLEASE ATTACH ANY SUPPORTING CLINICAL DOCUMENTATION SUPPORTING THE EXCEPTION REQUEST.
SITE OF CARE EXCEPTION REQUESTS WITHOUT SUPPORTING DOCUMENTATION WILL BE DENIED.

☐ INITIAL REQUEST ☐ RENEWAL REQUEST ☐ SITE OF CARE EXCEPTION REQUEST

DRUG NAME AND STRENGTH:		DIAGNOSIS (ICD-10):	
HCPCS CODE:	BODY SURFACE AREA:	HEIGHT:	WEIGHT:
DOSING REQUESTED:	THERAPY START DATE:	THERAPY END DATE:	

IS THE PATIENT CURRENTLY BEING TREATED WITH REQUESTED DRUG? ☐ YES ☐ NO
IF YES, PLEASE INDICATE DATE TREATMENT BEGAN:

PLEASE LIST ALL OTHER MEDICATIONS THE PATIENT WILL BE TAKING IN **COMBINATION** WITH THE REQUESTED MEDICATION FOR THIS **DIAGNOSIS**:

FOR **NON-ONCOLOGY OFF-LABEL REQUESTS**, PLEASE PROVIDE/ATTACH ANY REFERENCING MEDICAL LITERATURE SUPPORTING THE OFF-LABEL USE (SEE PHARMACY POLICY PP/0001 OFF-LABEL DRUG USE)

FOR **ANTI-NEOPLASTIC/ONCOLOGY REQUESTS**, INDICATE NATIONAL COMPREHENSIVE CANCER NETWORK® (NCCN) GUIDELINE/S USED (TITLE/S, VERSION/S, AND APPLICABLE PAGE/S [AS SPECIFIC AS POSSIBLE

MEDICATIONS TRIED AND FAILED FOR THIS DIAGNOSIS:

1.	2.
3.	4.

Please note that this, and other PreferredOne prescription prior authorization requests, can be completed online at **PreferredOne.com/providers**.
For assistance locating these forms, please reach out to PreferredOne Customer Service at 800.997.1750 Option #3.