



For Medicare Outpatient Biopharmacy/Buy and Bill Requests:

Check for urgent requests

Please FAX this completed form to: 1-844-941-1330

PA requests with missing/incomplete required fields may be denied due to lack of information. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.

I. Member Information:		II. Prescriber Information:	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Phone:	
Medication Allergies:		Fax:	
Member's Height:		Prior Auth Contact Name:	
Member's Weight (kg.):		Prior Auth Contact Phone:	
III. Diagnosis (as relevant to this request):			
Diagnosis:		ICD10:	
Date of Diagnosis:		NOTE: Include diagnostic clinicals (labs, radiology, etc.)	
IV. Drug Information (only ONE drug per form):			
HCPCS code:		Medication Name:	
Strength:		Dosage Form/Administration route:	
Start Date:		Directions for Use (sig):	
End Date:		Total Number of Visits requested:	
V. Medication History for Diagnosis:			
A. Is the member currently treated on this medication?			
<input type="checkbox"/> Yes. How long? _____ [go to item B] <input type="checkbox"/> No [skip items B & C; go to item D]			
B. Is this request for continuation of a previous approval from Pennsylvania Health & Wellness?			
<input type="checkbox"/> Yes [go to item C] <input type="checkbox"/> No [skip item C; go to item D]			
C. Has strength, dosage form, quantity, or frequency increased or decreased?			
<input type="checkbox"/> Yes. New directions: _____ <input type="checkbox"/> No			
D. Please indicate previous treatment and outcomes below (previous medications tried and failed & non-pharm treatment)			
Drug Name or Therapy/Directions (sig)	Dates of Therapy (start and end dates)	Reason for Discontinuation	
1)			
2)			
3)			
4)			
5)			
VI. Rationale for Request and Pertinent Clinical Information:			
NOTE: Supporting documentation (such as office chart notes, lab results, prior therapy and other clinical information) is REQUIRED for consideration of approval.			
Prescriber Signature:		Date:	