REQUEST FORM FOR HOME INFUSION THERAPIES

Non-Urgent Requests Fax to Perform Rx Injectable Management Program at: **866-369-6041**.
Urgent Request Fax to Perform Rx Injectable Management Program at: **866-533-5497**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a PerformRx Representative call: **866-369-6037**.

Patient Name Members ID#:
Address: Apt/Suite:
City/State: Zip Code: Phone: DOB:

Physician Name: NPI #:
Address: Apt/Suite:
City/State: Zip Code:
Phone: Fax: Contact Person:
Physician Signature:
Home Infusion Provider:
Address:
City/State Zip Code:
Phone: Fax: Contact Person

Please answer questions 1 - 3 and then complete the following Sections that Apply

1. How will the medication(s) be administered?(please check) _____ Infusion Pump, _____ IV Push _________Other (please name)___________________
2. Where will the medication(s) be administered?(please check) _______ Patient's Home _______ Physician's Office ________ SNF/LTC Facility
3. If administered in SNF/LTC Facility please provide name of facility: ____

A. Requests for Intravenous Antibiotic Therapy Diagnoses:________________________________ ICD-9 Code:____________

Medication Name	Dose	Frequency of Administration	Start Date	End Date
________________	____	_______________________	________	_______
________________	____	_______________________	________	_______
________________	____	_______________________	________	_______

B. Intravenous Immune Globulin (IVIG) requests that don't meet Part B coverage requirements

Patient Weight: __________lbs, ___________Kg Diagnoses:____ ICD-9 Code:____________

Medication Name	Dose	Frequency Of Administration	Start Date	End Date
________________	____	_______________________	________	_______
________________	____	_______________________	________	_______

Medical reason for why recommended first line therapies cannot be used to treat the member's condition: **Attach letter of Medical Necessity to Order form and reason why the IVIG request should not be covered under the members Medicare Part B benefit.**

C. Total Parenteral Nutrition (TPN) requests that don't meet Part B coverage requirements – Complete or submit letter of medical need that addresses all the below requested information.

Start Date of TPN:_______________, Anticipated End Date of Therapy:__________________
Pre-TPN Patient Weight: __________lbs, ___________Kg Diagnoses:____ ICD-9 Code:_____________
Pre-TPN Labs: Albumin Level:______________, Date of Lab:____________ Pre-Albumin Level:______________, Date Of Lab:________________
Anticipated Length of Treatment:____________________________________Goal Weight: _____________, Goal Albumin Level:_______________

Clinical Goals of Therapy:____
____

Medical reason for why member cannot receive nutrition by mouth and via tube feeding:
____

Is the administration of the TPN due to "permanent" dysfunction of digestive tract and the member is being provided the medication from either a Long Term Care pharmacy setting, Retail setting, or Home Infusion setting? _____NO_____YES (If yes, please provide reason why the TPN request should not be covered under the members Medicare Part B benefit.:____
____

Current Formulation of TPN (may attach order to form):____
____

Updated Information - Only for Renewal of TPN Therapy (Must complete the above TPN section for Renewal of Therapy):
Current Weight :__________lbs, ___________Kg
Current Labs: Albumin Level:______________, Date of Lab:____________ Pre-Albumin Level:______________, Date Of Lab:________________

D. Miscellaneous Therapy Requests

Diagnoses: ________________________________ Start Date:__________________, End Date__________________,
Patient Weight: __________lbs, ___________Kg Diagnoses:____ ICD-9 Code:_________________
Medication Name: ____Dose:________________ Frequency Of Administration: ____________________
Medical Necessity Information – Attach additional information if necessary:
____

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