



FROM

**Biopharmacy Medication Request Form**

Fax to: 18558659469

*This form is for **office injections or infusions**.  
For questions, call 1-833-472-1280*

- Standard Request** - Determination within 2 business days of receiving all necessary information.  
 **Urgent Request** - Determination within 2 business days of receiving all necessary information.

MEMBER INFORMATION		PRESCRIBER INFORMATION	
Member ID #:		Name:	
First Name:		Specialty:	
Last Name:		NPI #:	
Date of Birth:		Group or Hospital:	
Street Address:		Street Address:	
City, State, Zip:		City, State, Zip:	
Height:		Phone:	
Weight:		Fax:	
		Contact Name:	
SERVICING PROVIDER/MEDICATION SUPPLIER (choose from the options below)			
<input type="checkbox"/> <b>Dispense from Pharmacy</b> (Do NOT Use This Form) <input type="checkbox"/> <b>Dispense from Office, Hospital, Outpatient Center Stock</b>			
A. Location Name:			
B. Location NPI #:			
C. Phone:		Fax:	Contact Name:
INSURANCE INFORMATION			
Primary Insurance:		Secondary Insurance:	
ID Number:		ID Number:	
Phone Number:		Phone Number:	
DIAGNOSIS			
Diagnosis Date:		Diagnosis:	ICD10:
<b>COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION. NOTE: Include diagnostic clinicals (labs, radiology, etc.). For chemotherapy medication requests, include regimen and anticipated dates of service</b>			
MEDICATION HISTORY			
A. Is the member currently treated with this medication?			
<input type="radio"/> YES; How long? [go to item B] <input type="radio"/> NO [skip items B & C; go to item D]			
B. Is this request a continuation of a previous approval by Ambetter from Absolute Total Care?			
<input type="radio"/> YES [go to item C] <input type="radio"/> NO [skip item C; go to item D]			
C. The strength, dosage, or quantity required per day has:			
<input type="radio"/> INCREASED [go to item D] <input type="radio"/> DECREASED [go to item D] <input type="radio"/> REMAINED THE SAME [go to item D]			
D. Indicate PREVIOUS medications treatment/outcomes below.			
Drug Name, Strength, and Dosage		Dates of Therapy	Reason for Discontinuation
1.			
2.			
3.			
MEDICATION REQUESTED (NOTE: You must list the package size NDC for claim or the request will be returned.)			
Medication Name/ NDC/JCODE		Dosage/ Strength:	
Quantity:		Directions:	
Refills:		Start and End Date:	

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