# 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)

☐ **Dispense from Pharmacy** (Do NOT Use This Form)
☐ **Dispense from Office, Hospital, Outpatient Center Stock**

| | | |
|---|---|---|
| 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: |

**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*

**MEDICATION HISTORY**

A. Is the member currently treated with this medication?
☐ YES; How long? [go to item B] ☐ 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?
☐ YES [go to item C] ☐ NO [skip item C; go to item D]

C. The strength, dosage, or quantity required per day has:
☐ INCREASED [go to item D] ☐ DECREASED [go to item D] ☐ 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/<br>NDC/JCODE | Dosage/<br>Strength: |
| Quantity: | Directions: |
| Refills: | Start and End Date: |