

REQUEST FORM FOR HOME INFUSION THERAPIES

Non-Urgent Requests Fax to Perform Rx Injectable Management Program at: **866-369-6038**
Urgent Request Fax to Perform Rx Injectable Management Program at: **866-533-5491**. 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: **866-533-5490**.



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: _____

