Medical Infusible Medication Request Form

For medications administered by a contracted provider and billed as a medical claim

This form should only be used to request new-to-market medications or if the online application is unavailable. Otherwise authorization requests should be submitted as follows:

- **Non-contracted providers**: Call HAP Referral Management Team at **(313) 664-8950**
- **Contracted providers**: Log in at **hap.org** and select *Authorizations*

Instructions

1. Determine if the request should be submitted to HAP or our specialty pharmacy vendor. Log in at **hap.org**; select *Quick Links*; *Procedure Reference Lists*; *Services that Require Prior Authorization List*. Search for the drug and refer to the "key" column.
2. Some requests must include specific information. Log in at **hap.org** and select *Benefit Admin Manual* under *More*. Search by medication name to find relevant policies.
3. If this request is for off-label indication, published clinical evidence is required.
4. Complete, print and fax the form to **(313) 664-5338**.

Urgent Requests

A request is considered urgent when the standard time frame for response could seriously jeopardize patient life, health, or the ability to recover. Justification and direct contact information are required.

Urgent request justification _____

Prescriber direct contact information _____

Medication Request Information (each section must be completed)

Patient Name: _____

Patient ID#: _____ Patient DOB: _____

Requesting provider information	**Servicing provider information (if different than requesting)**
Name:	Facility or provider name:
NPI:	NPI:
Specialty:	Specialty:
Telephone:	Telephone:
Fax:	Fax:
Address:	Address:
Where will medication be administered?	☐ Patient's home ☐ Outpt hospital ☐ Office ☐ Infusion center ☐ Skilled nursing facility
Medication requested: (e.g., Prolia, Opdivo, Xgeva)	Dosage form (e.g., IV, SC, IM):
HCPCS Code:	SIG:
Dose and frequency (e.g., 120 mg once monthly)	Therapy start date: Therapy end date:
Primary indication for use of medication: ICD10:	Patient weight: Patient height:

1. Does this patient have primary insurance with another insurance plan? (e.g., Medicare Part B)	☐ YES ☐ NO
2. If YES, to question 1, have you submitted request or claim for this drug to primary insurance? (If NO, stop and submit the request or claim to the primary insurance. Do not fill out this form).	☐ YES ☐ NO

Clinical Rationale

3. Reason for medication request (please be specific):
4. Other medications tried and/or failed (please be specific and provide detail):
5. Other pertinent medical history (relative or pertinent to this request):

MEDICAL RECORDS, OFFICE NOTES, LABS ARE REQUIRED TO BE SUBMITTED WITH THIS REQUEST.

I CERTIFY THE ABOVE INFORMATION IS TRUE AND ACCURATE, AS WELL AS SUPPORTED BY MEDICAL RECORDS.

Prescriber signature _____

Printed Name _____ Date _____