HealthSun
HEALTH PLANS

SPECIALTY MEDICATION REQUEST FORM

ALL REQUIRE MEDICAL RECORDS TO BE ATTACHED

Phone: (877) 207-4900
Fax: (305) 448-4148

INSTRUCTIONS

This form is for Pre-Certification requests, which will be processed as quickly as possible depending on the member's needs.

Please fax all supporting documentation: clinical notes, laboratory results including Hgb levels, creatinine clearance, cultures and sensitives, etc.

IMMEDIATE OR EXPEDITED REQUESTS: Do not write STAT, ASAP or Immediate on this form. Please follow the instructions below. Medicare defines expedited as a request where "applying the standard time for making a determination could jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function".

ONLY COMPLETE THIS SECTION FOR EXPEDITED REQUESTS

If the PHYSICIAN believes the member meets this definition please:

1. Physician ***call*** (877) 207-4900 to speak with our Medical Director to expedite your request, **or**
2. Physician ***document the reason he/she feels the member meets the Medicare definition of expedited.***

_____

_____

Note*: HealthSun will process Part B expedited request within 24 hours and standard requests within 72 hours*.

Date of Request:	

Member Information:	
Member's First Name	
Member's Last Name	
Member ID #	
Member Address	
City, State, Zip Code	
Phone	
DOB	
Ht/Wt (lb/kg)	
Allergies	
DX	

Requesting Office:	
Provider (PCP) Name	
TIN # / NPI #	
Phone	
Fax	
Contact Person	
Ordering Physician	
Name	
TIN # / NPI #	
Phone	
Fax	

- Requests for Procrit, Epogen, and Aranesp will require laboratory results within 30 days prior to the request
- Red Cell stimulators will be approved for 60 days then additional lab results are required
- Requests for Herceptin & Erbitux will require supporting documentation of completion of marker testing

(Please use another form if more lines are needed)

HCPCS Code(s)	Medication	Dose	Start Date	Frequency	Length of Treatment

Please answer all of the questions below for a thorough review.

1) Is the medication being administered in the physician's office? Yes □ No □
   - Will the Physician “Buy and Bill” (Physician will be responsible to collect co-payment)? Yes □ No □
   - Will medication be sent to the provider’s office for administration (Pharmacy is responsible for collecting the medication co-payment)? Yes □ No □

   Preferred Health Plan Pharmacy (Plan to select only): _____

   Phone Number: _____ Fax Number: _____

2) Is the medication being administered at a facility or outpatient center? Yes □ No □

   Please (circle) one: Facility / Outpatient Clinic / Skilled Nursing Facility

   Facility / Clinic Provider Name _____ ID #_____

3) Is the medication being administered by a health-care professional in patient's home? Yes □ No □

Signature of Ordering Physician: _____ Date: _____