CareOregon

Home Infusion Prior Authorization Form – Revised December 2018

Please fax form and chart notes to **503-416-4722**

Use this form for 1) Drugs to be administered using an external or implantable infusion pump in the home and 2) Drugs to be administered in the home through an IV drip or a push injection.

Turn-Around Time Requested:	☐ Standard/Specified Date (If Possible): _____	☐ Urgent/Life Threatening (72 Hours)

Date: ____/____/____	Provider (Agency/Vendor) Name: _____	Tax ID #: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Member Name: _____ (Last First)	DOB: ____/____/_____	Member ID #: _____

Prescribing Provider Name: _____	Phone #: _____	Fax #: _____

Primary Dx Code: _____	Description: _____	Dx Code: _____	Description: _____

Comments: _____

Record applicable HCPCs and CPTs:		Expected Duration of Therapy: _____
Code: _____	Description: _____	Quantity: _____
Code: _____	Description: _____	Quantity: _____
Code: _____	Description: _____	Quantity: _____
Code: _____	Description: _____	Quantity: _____
Code: _____	Description: _____	Quantity: _____
Code: _____	Description: _____	Quantity: _____
Code: _____	Description: _____	Quantity: _____
Code: _____	Description: _____	Quantity: _____