CarePlus HEALTH PLANS

MEDICAL PRECERTIFICATION REQUEST FORM

EOC ID:
Universal B vs D 40
Phone: 1-866-315-7587 Fax back to: 1-800-819-6204

CarePlus manages the pharmacy drug benefit for your patient. Certain requests for precertification may require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. **Information left blank or illegible may delay the review process.**

Patient name:	**Prescriber name:**
	Fax:
Member/subscriber number:	Phone:
Patient date of birth:	Office contact:
	Tax ID:
Group number:	NPI:
Address:	Address:
City, state and ZIP code: ,	City, state and ZIP code: ,
	Specialty/facility name (if applicable):

☐ By checking this box, I am requesting multiple drug reviews for this patient.

Expedited/exigent/urgent

☐ By checking this box, I certify an expedited/exigent/urgent review is required. The patient has a health condition that may seriously jeopardize their life or ability to regain maximum function. **(Please include explanation of exigency in the space below.)**

Drug name and strength:	Dose per infusion/injection:
Directions/SIG:	Number of infusions/injections:
Quantity/units:	Number of cycles/frequency:

Please provide date of service: __/__/____ (Note: If no date is specified, the date the request was received will be utilized.)

(Note: All reviews will be processed with generic equivalents for brand-name drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide diagnosis: *

Q2. Please provide J-Code, if applicable:

Q3. Please provide ICD Diagnostic Codes:

Q4. Please indicate which one of the following applies: *

☐ Prescriber supplied

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☐ Pharmacy shipped to prescriber
☐ Pharmacy dispensed to patient
☐ Supplied by pharmacy and administered in home health service, long term care, or skilled nursing facility

Q5. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q6. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied (e.g. ClinicalTrials.gov Identifier: NCT12345678): *

Q7. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Q8. Will the drug be administered by an implantable infusion pump? *

☐ Yes ☐ No

Q9. Will the drug be administered by an external infusion pump? *

☐ Yes ☐ No

Q10. If the drug will be administered by an external infusion pump, please indicate if one of the following applies: *

☐ Administered in a home setting
☐ Administered in an assisted living facility
☐ The patient resides in one of the following long-term care (LTC) facilities: A nursing home that is dually-certified as both a Medicare (SNF) and a Medicaid nursing facility (NF); OR A Medicaid-only NF that primarily furnishes skilled care; OR A non-participating nursing home (i.e. neither Medicare nor Medicaid) that provides primarily skilled care; OR An institution which has a distinct part SNF and which also primarily furnishes skilled care

Q11. Will the requested drug be used for Insulin in a Pump, Immunosuppressant for Transplant, or HIV PrEP? *

☐ Yes ☐ No

Q12. If yes, does the request need backdated if approved? *

☐ Yes ☐ No

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Q13. If backdate is required, please provide the date that the back date request is for: *
Q14. For chemotherapy requests, please provide all antineoplastic medications being used in the chemotherapeutic regimen:
Q15. For chemotherapy requests, please provide all pertinent information to the review regarding the patients cancer staging, tumor grading, and/or TNM classification (or chart notes that may contain this information) if available:
Q16. For chemotherapy requests, please provide which line of chemotherapy this represents for the patient (eg. first line, second line, etc.):
Q17. Additional Comments:

Prescriber signature

Date