PRECERTIFICATION REQUEST FOR IV THERAPY*

MEMBER NAME: _____ **ID#:** _____

MEMBER PHONE NUMBER: _____

ORDERING PHYSICIAN: _____

PHYSICIAN PHONE #: _____

DIAGNOSIS REQUIRING IV THERAPY: _____

_____

HOW WAS THE DIAGNOSIS ESTABLISHED?: _____

_____

OTHER DIAGNOSES: _____

PLEASE COMPLETE THIS SECTION COMPLETELY

	Drug	Dose	Frequency	Expected Duration (days)
Drug 1				
Drug 2				
Drug 3				

REASON FOR IV THERAPY: Please check all that apply in the boxes below.

Failed prior oral treatment	No oral or IM alternative	Unable to absorb oral	Unable to tolerate oral	Bleeding tendency prohibits IM	Other (explain below)

OTHER REASON: _____

_____

Form Completed By: _____ Phone #:_____

* May require a letter of medical necessity from prescribing physician.
Please fax or call the Precertification/Utilization Management number below for ongoing therapy.

UTILIZATION MANAGEMENT PHONE: 800-254-0130 FAX: 732-562-1023