HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) AUTHORIZATION FORM

(form effective 7/30/20)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

Confidential information

Patient name:		
Patient date of birth (MM/DD/YYYY): / /	Patient ID number:	
Physician name:	Specialty:	
Phone:	Fax:	NPI:
Physician street address:		
City:	State:	ZIP code:
Facility name:	Facility NPI:	
Medication name and strength requested:	J-code: Number of units: Date of service (MM/DD/YYYY): / /	
Directions:		
Anticipated length of therapy: ☐ days ☐ 3 months ☐ 6 months		
Treatment setting: ☐ Infusion Center ☐ Home ☐ Provider's Office ☐ Hospital Outpatient Facility		
Diagnosis:		
Preferred medications tried/Previous therapy. Please include strength, frequency, and duration. (If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs.)		
Rationale for hospital outpatient facility treatment setting (if applicable): ☐ Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions ☐ Documentation that the member is medically unstable for the safe and effective administration of the prescribed medication at an alternative site of care as a result of one of the following: ☐ Complex medical condition, status, or therapy requires services beyond the capabilities of an office or home infusion setting (clinical instability or a complex regimen that requires frequent clinical assessment or monitoring, which would be beyond the capabilities of an office or home infusion setting) ☐ Documented history of medical instability, significant comorbidity, or concerns regarding fluid status inhibits treatment at a less intensive site of care (unstable fluid status associated with heart failure or advanced [stage 4 or 5] renal failure)		
Rationale and/or additional information that may be relevant to the review of this prior authorization request. (If more space is needed, please attach an additional page to this document.)		
Physician signature:	Date (MM/DD/YYYY): / /	

Important payment notice

Please note that reimbursement for all rendering network providers subject to the ordering/referring/prescribing (ORP) requirement for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medical Assistance (MA) Provider ID. Effective January 1, 2018, any claim submitted by rendering network providers that are subject to the ORP requirement will be denied when billed with the NPI of an ORP provider that is not enrolled in MA.

To check the MA enrollment status of the practitioner ordering, referring, or prescribing the service you are providing, visit the Department of Human Services (DHS) provider look-up portal at: **https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider**.