Print Form

Clear Form

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Home Infusion Therapy Prior Authorization Form

Please complete and fax with the physician's prescription to: (888) 641-5355. If the patient is a BCBSMA employee, please fax the form to: (617)246-4013. If the patient is a Blue MedicareRx member, please fax the request to Anthem Blue Cross Blue Shield at (866) 827-9822.

FOR TPN THERAPY, USE MEDICAL POLICY #296 REQUEST FORM

Company name:		Contact Name:			
Phone #:		Provider #:			
Fax#		Address:			
Patient name:		Address:			
Patient ID#:		DOB: / /	Diagnosis: (ICD-10)		
Prescribing Physician/addr:			Telephone:		
PCP name/address:			Telephone:		

Place of Service ☐ Home ☐ SNF ☐ MD office ☐ other (specify)

Primary Therapy

Primary drug name: Approximate duration: / / to ____/____/____

Dose: _____

Frequency: _____ Route of Administration: _____ pump: Y___ N___

Other Therapy

Other drug name:_____ Approximate duration: ____/____/____ to ____/____/____

Dose: _____

Frequency: _____ Route of Administration: _____ pump: Y___ N☐

☐ If this is a "drug only" authorization request, indicate other services the nursing agency is providing:

Nursing provided by: _____ Contact: _____

Phone: _____ Fax:_____

Request for 7 Day Coverage: Date of occurrence:_____ Request dates:_____

Occurrence type: ☐ Hospitalization ☐ Death ☐ Change of Therapy

Physician signature:_____ Date:_____

OR Copy of prescription REQUIRED with this request.