Site of Care
Prior Authorization Request Form

This form is to be completed by the prescribing provider and staff. Please complete in full to avoid a processing delay. Fax completed forms.

Patient Information		
Patient's Name (Last, First, MI):		
Member ID:	Date of Birth:	
Requesting Provider Information		
Requesting Physician/Provider's Name:	Specialty:	
NPI:	Tax ID No:	
Address:		
Phone:	Fax:	
Contact Name:	Phone:	Fax:
Requested Site of Care Location Information		
Requested Site of Care Location:	Start Date:	
Address:		
Phone:	NPI:	Tax ID:
Drug Information		
Drug to be Administered:		ICD-10:
Dosage:	Directions:	Length of Therapy:

Medical reasons for requiring higher level of care provided at hospital-based infusion centers, as written in the policy criteria, are as follows: recent documented history of severe adverse drug reaction to same or similar therapy; concomitant complex medical conditions; medication part of concurrent complex drug regimen of which at least one require higher level or care; history of chronic vascular access complications; and mental health or cognitive changes requiring increased level of care. Please refer to our policy on ProvLink for details.

Please indicate below medical reasons why your patient requires infusion therapy at a hospital-based infusion center. Please submit supporting medical documentation.

_____

_____

_____

_____

_____

☐ Urgent Request

Requesting Provider's Signature:_____Date:_____

STRICT CONFIDENTIALITY IS MAINTAINED FOR ALL MEDICAL INFORMATION AND REQUESTS.

Any additional information needed will be requested via telephone or fax. Your office will be notified by fax of the decision.

Providence Health Plans ATTN: Pharmacy Services PO Box 3125 Portland, OR 97208	Fax 503-574-8646 or 800-249-7714	Questions Please Call 503-574-7400 or 877-216-3644

www.providence.org/healthplans