



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Specialty Infusion Drugs Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call Healthlink at 1-877-284-0102.

Provider Information

Provider/Facility Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Patient Information

Patient Name: _____
 Patient DOB: _____
 ID Number: _____
 Address: _____
 Phone: _____

Ordering Physician Information

Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Treatment Information

Primary Diagnosis: _____
 Diagnosis (ICD-9) Code: _____

Chemotherapy Agent	J Code	Dosage	Route	Frequency	Start Date	End Date

Will the chemotherapy be? Inpatient Outpatient Home
 If inpatient, what is the requested length of stay? _____
 What is the primary site of the cancer? _____
 Are there metastatic sites? YES NO
 If yes, please list where? _____
 What is the cell type? _____
 What is the date of initial diagnosis? _____

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Is this a recurrence? YES NO

If yes, what is the date of recurrence? _____

What is the stage of disease? _____

Has the patient had prior treatment? YES NO

If yes, list previous treatment: _____

Has the patient had surgery related to the diagnosis? YES NO

If yes, please list date and type of surgery: _____

Is the patient part of a study? YES NO

What is the route of Chemotherapy? _____

Are any drugs being given as high dose? _____

Is this part of a stem cell or bone marrow transplant? YES NO

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____