BIOSCRIP PBM SERVICES

PRIOR AUTHORIZATION/MEDICAL NECESSITY REQUEST FORM

Call Clinical Services Department at 1-800-555-8513 or Fax 1-800-583-6010. BioScrip will respond by fax or phone within 24 hours of receipt of this request.

Member's Name: _____
First Middle I. Last

Member's ID Number: _____ Date of Birth: _____/_____/_____

Member's Insurance Plan: _____Group Name:_____

Physician: _____ Contact Person at Office: _____

Phone Number: (_____) _____- _____ Fax Number: (_____) _____- _____

Requested Medication: _____ Medication Allergies: _____

Relevant Diagnosis: _____

Has the member been on this medication in the past? Yes / No If yes, for how long?_____

Previous Medication History:

Drug Strength and Dose	Dates of Therapy	Reason for Discontinuing the Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Rationale for Request:

_____

_____

_____

_____

_____

_____

Physician's Signature: ___ _____ Date: _____/_____/_____

In order to expedite processing, please include lab reports with requests when appropriate, e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC; etc.

Time Sent_____