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 this form and fax it with the physician's prescription to the number listed below.

Commercial and Medicare Advantage members: 1-888-641-5355
Federal Employee Program members: 1-888-282-1315
Blue Cross Blue Shield of Massachusetts employees: 1-617-246-4013
Blue MedicareRx members should be routed to Anthem Blue Cross Blue Shield: 1-866-827-9822.

FOR TPN THERAPY, USE MEDICAL POLICY #296 REQUEST FORM

Company name:		Contact Name:	
Phone #:		Provider #:	
Fax#		Address:	
Patient name:		DOB:	
Patient ID#:		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: _____

Copy of prescription REQUIRED with this request.