Fax: (866) 343-1880

CARECONTINUUM™

Prior Authorization Request Fax Form

CARECONTINUUM is contracted to provide pre-certification and authorization of home health and/or home infusion services, MDO or AIC services. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Urgent (Circle One): Yes ☐ No ☐

Patient Name:

Member Number:

First Name: Last Name:

Date of Birth: Group Number:

Phone: Primary Dx Code:

Address:

City, State, Zip:

Height: Weight:

Prescriber Name:

Name:

Office Contact:

Fax: Phone:

NPI: State Lic ID:

Address:

City, State, Zip:

Billing Provider:

Name/Facility Name:

Office Contact:

NPI: State Lic ID:

Fax: Phone:

Address:

City, State, Zip:

Place of Service (Circle One): ☐ Home ☐ Physicians Office ☐ Outpatient ☐ Dialysis Center

Requested Drug Information:

Drug Name:

HCPCS/CPT:

Dose: Frequency:

Start Date: End Date:

Patient already on established therapy (Circle One): Yes ☐ No ☐

Direction:

Lab/Diagnostic Information: (if applicable)

CrCL:

SCr:

T-Score:

Hemoglobin:

Hematocrit:

Transferrin Saturation:

Pre-Treatment Serum IgG Level:

Treatment Serum IgE Level:

Ferritin:

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Prior Medication/ Therapy	Adverse Reaction	Tx Failure	Date Started	Length of Therapy

*** Attach additional pages if necessary

ATTACH COPY OF PRESCRIPTION HERE

Physician Signature **Date**