



REVIEW REQUEST FOR
Prialt® Intrathecal Infusion –Medical Policy-DRUG.00027
Provider Data Collection Tool Based on Medical Policy DRUG 00027
Complete form in its entirety and fax to:
Empire: 888-309-9672

Policy Last Review Date: 02/26/09	Policy Effective Date: 04/22/09	Provider Tool Effective Date: 02/18/10
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Request Date: / /		
<input type="checkbox"/> Initial Authorization Request		<input type="checkbox"/> Subsequent Request
<input type="checkbox"/> Buy and Bill		
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by Precision Rx Specialty Solutions (800-824-2642)FAX Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Member's Home <input type="checkbox"/> Other: (please specify): _____		
Member Name:		Date of Birth: / /
Insurance Identification Number:		Member Phone Number:
Primary Diagnosis:	ICD-9 Code(s) (if known):	Member's Weight <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
Ordering Provider Name & Specialty:		Provider ID Number:
Office Address:		
Contact and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty (If different than Ordering Provider):		Provider ID Number:
Office Address:		
Contact and Office Phone Number:		Office Fax Number:
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____		
Drug Name/HCPS Code (if known) Prialt <input type="checkbox"/> J2278 Other: _____		Dose to be administered: _____ (units)
When did the member first start this drug? / /		Frequency (Days, Wks, Months) _____
Duration: _____ (Weeks)		Start Date For This Request: / /

Please check all that apply to the member:
 NOTE: To avoid delays, please complete this form in its entirety

(1) Severe Chronic Pain

- Member has severe chronic pain in which intrathecal therapy is needed
- Member is intolerant of or refractory to other systemic analgesics **If checked, Please list drug(s)** _____
- Member is intolerant of or refractory to adjunctive therapies **If checked, Please list drug(s)** _____
- Member is intolerant of or refractory to intrathecal morphine **If checked, Please list drug(s)** _____

(2) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

Pre-Claim

Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that Anthem may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

/ /
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**
