

REVIEW REQUEST FOR

Prialt® – Intrathecal Infusion

Provider Data Collection Tool Based on Medical Policy DRUG.00027

Complete form in its entirety and fax to:

**Anthem UM
Services, Inc.**

**AIM Specialty Pharmacy Review
(888) 223-0550**

Policy Last Review Date: 02/17/2011	Policy Effective Date: 04/13/2011	Provider Tool Effective Date: 04/13/2011
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Request Date: / /		
<input type="checkbox"/> Initial Request <input type="checkbox"/> Subsequent Request		
<input type="checkbox"/> Buy and Bill		
Individual's Name:		Date of Birth: / /
Insurance Identification Number:		Individual's Phone Number:
Primary Diagnosis:	ICD-9 Code(s) (if known):	Individual's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
Ordering Provider Name & Specialty:		Provider ID Number (if known):
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty (If different than Ordering Provider):		Provider ID Number (if known):
Office Address:		
Contact Name 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 <input type="checkbox"/> Other: _____	Dose to be administered: _____ (mcg) _____ (Other)	
When did the individual first start this drug? / /	Frequency (Days, Wks, Months) _____	
Duration: _____ (Weeks)	Start Date For This Request: / /	

Please check all that apply to the individual:

NOTE: To avoid delays, please complete this form in its entirety

(1) Severe Chronic Pain

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

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

Anthem UM Services, Inc. is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan. Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

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 the health plan or its designees 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**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.