HealthPartners

Site of Care Request for Information Form

Member Name:_____ **Member ID:**_____ **Date of Birth:** _____

HealthPartners requires the use of office-based infusion settings or home infusion (when home infusion is medically appropriate) for this medical injectable. It is not considered medically necessary for a member to receive this drug at a high-cost setting (i.e., outpatient hospital setting), unless exception criteria are met which will be determined bythe 3 questions below. See the drug's medical policy posted online for full exception criteria.

*Is it medically necessary for this patient to receive infusion services at your outpatient hospital setting?

Yes ☐ No ☐

If no (not medically necessary), and the drug meets all other medical necessity criteria, then HealthPartners will still allow a 3 month approval at your outpatient hospital setting to allow time for patients to transition to an alternative setting. HealthPartners will contact the patient to facilitate selecting a new preferred alternative setting.

***Would you agree to change your request to a 3 month duration approval?**

Yes ☐ No ☐

If yes (medically necessary), answer the following three questions. Please provide supporting rationale for any "yes" responses in the form of a short statement:

1. Has the patient experienced a severe or life-threatening reaction with previous infusions of the same or similar products?

2. Is the patient medically unstable or otherwise high-risk such that continued oversight in an outpatient hospital setting is required? (If yes, please provide details regarding the medical instability of the patient and specific risks that make office-based infusion and home-infusion inappropriate for the patient)

3. Does the patient have a high-risk home environment, which would not allow the use of home-infusion services? (This may include unstable housing or housing deemed unsanitary or unfit for infusion services documented by the physician, social worker, or infusion provider).

Pharmacy Administration - Prior Authorization / Exception Form

For questions, call **952-883-5813** or **800-492-7259**.
Incomplete or illegible submissions will be returned and may delay review.

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FAX to 952-853-8700 or 1-888-883-5434

	Will waiting the standard review time **seriously jeopardize** the life or health of the member or the member's ability to regain maximum function?	Yes ☐ No ☐
Patient	Last Name / First Name / MI	
	Date of Birth / HealthPartners Insurance ID #	
	Address / Weight / BSA	
Provider	Today's Date / Clinic Name	
	Provider Name (FIRST and LAST) / Clinic Address	
	Specialty / Telephone #	
	Provider NPI / Fax #	
	Contact Person / Recommended by a Consultant? ☐ Yes ☐ No; Name / Specialty	
Requested Therapy	Drug Requested & Dosing Schedule / Brand Name Necessary	
	Date Therapy Initiated / Requested Start Date / ☐ YES ☐ NO	
	ICD-10 Diagnoses (Primary first)	
	Previous Therapies & Outcomes / Prescribing Rationale	
	If **injectable** medication, how is it being administered? ☐ Self-administered ☐ Professionally-administered	
Facility	Administering Facility Information (**REQUIRED** for Professionally-administered drugs)	
	Name / Address	
	Federal Tax ID / NPI	
	Facility type: ☐ Clinic ☐ Outpatient Hospital ☐ Home Infusion ☐ Ambulatory Infusion Suite	

HealthPartners Preferred Drug List (Formulary), Prior Approval and Medical Coverage Criteria are available at www.healthpartners.com