



Horizon Blue Cross Blue Shield of New Jersey

Date of Request : \_\_\_\_\_

In place of this Form you can submit Authorization Requests Online securely via Navinet. If you are not registered, please visit Navinet.net and click Sign Up or call Navinet Customer Care at 1-888-482-8057.

**Infusion Authorization Request Form**

Requirements: Clinical information and supportive documentation should consist of office visit notes and recent diagnostic test. Test results must be submitted to support request for approval. Notification required for any date of service change. Please complete this form in its entirety, in order to prevent processing delays.

Fax completed form to: Horizon NJ TotalCare (HMO SNP) at 1-609-583-3013

**General Information**

Member Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

Provider Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

List Any Additional Insurance: \_\_\_\_\_ Policy Name/Number: \_\_\_\_\_

**Medical Information Needed**

Date/Date Range of Service: \_\_\_\_\_

Days/Units Requested: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Other Chronic Diagnosis: \_\_\_\_\_

ICD-10 Codes: \_\_\_\_\_

Procedures(s) Requested: \_\_\_\_\_

CPT Codes Requested: \_\_\_\_\_

Name of infusion medication:      **Iron**      **Remicade**      **Other**

Requesting Provider: \_\_\_\_\_ ID# & NPI#: \_\_\_\_\_ TIN# \_\_\_\_\_

Servicing Facility: \_\_\_\_\_ ID# & NPI#: \_\_\_\_\_ TIN# \_\_\_\_\_

Location of Service:      MD Office      Outpatient Hospital      Hospital SPU/OR      Other

**Additional Required Information**

**If Requesting Iron:** (Please send Hemoglobin & Hematocrit for past 3 months and recent iron levels within past 30 days).

Anemia due to: \_\_\_\_\_ If Gyn related – Is Ob/Gyn addressing diagnosis?    Yes    No

List two (2) oral therapies attempted: \_\_\_\_\_

Failure due to: \_\_\_\_\_

**If Requesting Remicade:** Is member being managed by Rheumatologist:    Yes    No

Received Remicade previously:    Yes    Date: \_\_\_\_\_    or    No    Weight: \_\_\_\_\_

Is Disease active:    Yes    No    Mild    Moderate    Severe

Rheumatoid Arthritis DMARD Therapy:    Yes    No    List: \_\_\_\_\_

Crohn's Disease Fistulizing disease:    Yes    No    Other previous therapies: \_\_\_\_\_

Is member in the MS Touch Program?    Yes    No