



Horizon Blue Cross Blue Shield of New Jersey

Date of Request: _____

Injectables Authorization Request Form

Requirements: Clinical information and supportive documentation should consist of office visit notes and recent diagnostics. 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.

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.

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: _____

ICD 10 Codes: _____

Procedures(s) Requested: _____

CPT Codes Requested: _____

Requesting Provider: _____ ID# & NPI#: _____ TIN# _____

Servicing Facility: _____ ID# & NPI#: _____ TIN# _____

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

Required Information

Please check type of injectable

- Lupron
- Epogen Procrit
- Neulasta Granix

Euflexxa:
List of Medications tried: _____

Botox: Last dose given: _____ Infection present at injection site: Yes No