



SANTÉ COMMUNITY
PHYSICIANS

REQUEST FOR PRIOR AUTHORIZATION

FAX (559) 224-2405 or (559) 224-9746

Phone (559)228-5400 (800) 652-2900

Please check Health Plan

- | | | |
|--|--|--|
| <input type="checkbox"/> AARP Medicare Complete | <input type="checkbox"/> Blue Shield Access Plus | <input type="checkbox"/> Health Net Seniority Plus |
| <input type="checkbox"/> Aetna | <input type="checkbox"/> California Care | <input type="checkbox"/> Humana Medicare Advantage |
| <input type="checkbox"/> Aetna Medicare Advantage Plan | <input type="checkbox"/> Cigna | <input type="checkbox"/> United Healthcare Signature Value |
| <input type="checkbox"/> Blue Shield 65 Plus | <input type="checkbox"/> Health Net | <input type="checkbox"/> United Healthcare Medicare Solutions: Group Retiree |

SERVICES REQUIRING PRIOR AUTHORIZATION (please check requested service)

- | | |
|--|---|
| <input type="checkbox"/> Aqua Therapy | <input type="checkbox"/> M2A Video Capsule Endoscopy |
| <input type="checkbox"/> Breastfeeding Medicine Referral | <input type="checkbox"/> MRI, MRA, CT & Pet Scans |
| <input type="checkbox"/> Balance & Dizziness Referral | <input type="checkbox"/> Nutrition Consult for Chronic Disease (CMC) |
| <input type="checkbox"/> Colonoscopy; EGD | <input type="checkbox"/> Obesity - Referral to General Surgeon |
| <input type="checkbox"/> Cosmetic/Reconstructive Surgery | <input type="checkbox"/> Obesity Surgery |
| <input type="checkbox"/> DME Purchase over \$200 | <input type="checkbox"/> Out-of-Plan Provider |
| <input type="checkbox"/> DME Rental | <input type="checkbox"/> Plastic Surgery Referral |
| <input type="checkbox"/> Endocrinologist Visit (Type II Diabetes) | <input type="checkbox"/> Sleep Studies |
| <input type="checkbox"/> Home Health Home I.V. | <input type="checkbox"/> Transplants in conjunction with Health Plan Programs |
| <input type="checkbox"/> Infusions - Ambulatory (See reverse side of this form) | <input type="checkbox"/> Weight Management Program Referral |
| <input type="checkbox"/> Injections: Self-injectables; In-office injectables
(See reverse side of this form for more information) | |

TYPE OF REQUEST

- URGENT for acute conditions requiring care within 72 hours or less. NON-URGENT for routine, elective service

PATIENT INFORMATION

Patient Name: Last			First			MI			Date of Birth			(Mo/Day/Yr)		
I.D.#						Gender:			M			F		
Other Insurance?		Name of Carrier?			Job Related		MVA		Accident			Pregnancy Related?		
Yes No					Yes No		Yes No		Yes No			Yes		

FROM - REQUESTING PHYSICIAN

Requesting Physician (Please Print)						Tax ID#											
Contact Person in Requesting Provider's Office						Telephone						Fax					
Name of PCP						Signature of Requesting Physician						Date					

TO - WHERE WILL PATIENT RECEIVE SERVICES?

Physician/Provider/Facility Requested				Address				Telephone				Fax			
Where will services be rendered? (provide name of facility, if other than provider office or patient's home)															

Asst Surgeon Required? Y Yes No								Anesthesiologist Required? : Yes No							
Name:								Name:							

Today's Date:								Tentative Date of Service/Admission:							
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CLINICAL INFORMATION

ICD-9 Codes (required)						Diagnosis Description:						Date of Onset/Injury					
1		2		3													
CPT/HCPC Codes (required)						Describe Service Requested:						# of Days/Visits:					
1		2		3		4											

Comments:															
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Within 5 days before the actual date of service, provider MUST confirm that the member's health plan coverage is still in effect. With the exception of urgent requests, it is recommended that you do not schedule appointments prior to authorization approval. Emergency services do not require prior authorization and are reviewed retrospectively for necessity. This message is intended only for the use of the individual/entity to which it is addressed and may contain confidential information. If the reader of this message is not the intended recipient, you are hereby notified that any distribution is strictly prohibited.

EFFECTIVE 03/01/2011

Self-Injectables, In-Office Injectables, Infusions Prior Authorization List

Anti-infective Agents

Aloxi
Cancidas
Fuzeon
Rocephin – for Lyme
Disease Only

Antihemophilic Agents:

Bebulin VH
Factor VIII
Factor IX
Humate-P
Novoseven
Proplex T
Recombinant Factor VIII
Recombinant Factor IX

Antineoplastic Agents

Abraxane
Alimta
Arranon
Clolar
Eloxatin
Faslodex
Novantrone
Proleukin
Velcade
Vidaza

Bisphosphonate Agents

Boniva
Zometa

Colony Stimulating Factors

Aranesp
Epogen
Leukine
Neulasta
Neumega
Neupogen
Procrit

Anti-Rheumatic Drugs

Enbrel
Humira
Kineret
Orencia
Remicade

Enzyme Therapy Agents

Aldurazyme
Aralast
Ceredase
Cerezyme

Fabrazyme
Naglazyme
Prolastin
Zemaira

Anticoagulant Agents

Arixtra
Fragmin
Innohep
Lovenox

Growth Hormone Agents

Genotropin
Humatrope
Increlex
Saizen
Somavert

Immune Globulins

CytoGam
IVIG
Vivaglobulin

Interferons

Actimmune
Alferon-N
Avonex
Betaseron
Infergen
Intron-A
Pegasys
PEG-Intron
Rebetron
Rebif
Roferon-A

Monoclonal Antibody

Amevive
Avastin
Campath
Erbix

Herceptin
Lucentis
Macugen
Mylotarg
Raptiva
Rituxan
Synagis
Tysabri
Xolair

Peptide Agents

Byetta
Forteo
Natrecor
Sandostatin
Sandostatin LAR Depo

Viscosupplementation

Euflexxa
Hyalgan
Orthovisc
Supartz
Synvisc

Miscellaneous Agents

Botox
Copaxone
Flolan
Myobloc
Remodulin
Ventavis

Exclusions (does not require prior authorization):

* Re Self-Injectables:

*Insulin

*Blue Shield – Pharmacy Benefit

“With the exception of the exclusions listed above, self-injectables, infusions and high dollar injectables require prior authorization. This list may not contain every item requiring prior authorization. Please check with Santé UM staff if you are ordering/administering an infusion, self-injectable or high dollar injectable that is not listed here.”

EFFECTIVE 03/01/2011