

HCPCS (Healthcare Common Procedure Coding System) Authorization Form

Confidential information					
Patient name:					
Patient date of birth (MM/DD/YYYY):		Patient ID number:			
Physician name:					
Physician Tax ID:		Specialty:			
Phone:	Fax:	Fax:		Physician NPI:	
Physician street address:					
City:		State:		ZIP code:	
Facility name:					
Facility NPI:		Facility Tax ID:			
Facility street address:					
Facility city:		State:		ZIP code:	
Treatment setting: □ Infusion center □ Hospital outpatient facility □ Home infusion □ Provider's office					
□ Other:					
Medication name and strength requested:					
J-code: Nu	Number of units: Date of service (MM/DD/YYYY):				
Directions:					
Anticipated length of therapy: □ Days □ 3 months □ 6 months □ Other:					
Diagnosis:					
Preferred medications tried/previous therapy. Please include strength, frequency, and duration. (If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs.)					
Rationale and/or additional information that may be relevant to the review of this prior authorization request. (If more space is needed, please attach an additional page to this document.)					
Physician signature:		Date (MM/DD/YYYY):			

Please fax this form to PerformRx:

Standard fax: **1-855-839-3882**Urgent fax: **1-833-498-1208**

PerformRx Provider Services: 1-855-662-0279

