Home Infusion Prior Authorization Form

Revised July 2020

Please fax form and chart notes to 503-416-4722

CareOregon Advantage

Use this form for:

1) Drugs to be administered using an external or implantable infusion pump in the home; and
2) Drugs to be administered in the home through an IV drip or a push injection.

Turn-Around Time Requested: ◯ **Standard: specified date** (if possible): _____

◯ **Urgent/ life threatening:** (24 hours)

Date: _____ Provider (agency/vendor) name: _____

Tax ID#: _____ Contact person: _____ Phone #: _____ Fax #: _____

Member name: _____ DOB: _____ Member ID#: _____

Last First

Prescribing provider name: _____ Phone #: _____ Fax #: _____

Primary Dx code: _____ Description: _____ Dx code: _____ Description: _____

Comments: _____

Record applicable HCPCs and CPTs: _____ Expected duration of therapy: _____

Code: _____ Description: _____ Quantity: _____

Code: _____ Description: _____ Quantity: _____

Code: _____ Description: _____ Quantity: _____

Code: _____ Description: _____ Quantity: _____

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