Site of Care Request for Information Form

Member Name:_____**Member ID:**_____**Date of Birth:**_____

HealthPartners requires this medical injectable to be given by home infusion or at a clinic office, or to be dispensed by a specialty pharmacy if provided in an outpatient hospital site. See the drug's medical policy posted online for full criteria.

1. **Is it medically necessary** for this patient to receive infusion services at your outpatient hospital setting?
   (choose one) ☐ yes ☐ no

   (if yes, answer questions a, b, c and d. If no, answer question 2)

   a. If yes do you agree to obtain the medication through a specialty pharmacy?
      (choose one) ☐ yes ☐ no

      If yes, to which specialty pharmacy will you send the prescription? (choose one)
      i. HealthPartners specialty pharmacy network:
      ☐ CVS Specialty
      ☐ Fairview Specialty
      ☐ Accredo Specialty ii.
      ☐ Other (please specify)

   b. Has the patient experienced a severe or life-threatening reaction with previous infusions of the same or similar products? Please explain and provide supporting rationale.

   c. Is the patient medically unstable or otherwise high-risk such that continued oversight in an outpatient hospital setting is required? If yes, please provide details regarding the medical instability of the patient and specific risks that make office-based infusion and home-infusion inappropriate for the patient.

   d. Does the patient have a high-risk home environment, which would not allow the use of home-infusion services? (This may include unstable housing or housing deemed unsanitary or unfit for infusion services documented by the physician, social worker, or infusion provider). Please explain and provide supporting rationale.

2. **If you do not agree to obtain the medication from a specialty pharmacy,** and the drug meets all other medical necessity criteria, then HealthPartners will issue a 3 month approval at your outpatient hospital setting to allow time for the patient to transition to an alternative setting. HealthPartners will contact the patient to facilitate selecting a new preferred alternative setting or to enroll in specialty dispensing.

   a. Would you agree to change your request to a 3 month duration approval? (choose one) ☐ yes ☐ no

Pharmacy Administration - Prior Authorization / Exception Form

For questions, please call **952-883-5813** or **800-492-7259** Incomplete submissions will be returned and may delay review.

FAX to 952-853-8700 or 1-888-883-5434

	Will waiting the standard review time **seriously jeopardize** the life or health of the member or the member's ability to regain maximum function?	☐ Yes ☐ No
Patient	Last Name / First Name / MI	
	Date of Birth	HealthPartners Insurance ID #
	Address	Weight BSA
Provider	Today's Date	Clinic Name
	Provider Name (FIRST and LAST)	Clinic Address
	Specialty	Telephone #
	Provider NPI	Fax #
	Contact Person	Recommended by a Consultant? ☐ Yes ☐ No Name Specialty
Requested Therapy	Drug Requested & Dosing Schedule	Brand name necessary? ☐ Yes ☐ No
	Date therapy initiated	Requested Start Date & Duration
	ICD-10 Diagnoses (Primary first)	
	Previous Therapies & Outcomes / Prescribing Rationale	
	If **injectable** medication, how is it being administered? ☐ Self-administered ☐ Professionally-administered	
Facility	Administering Facility Information (**REQUIRED** for professionally-administered drugs)	
	Name	Address
	Federal Tax ID	NPI
	Facility Type ☐ Clinic ☐ Outpatient Hospital ☐ Home Infusion ☐ Ambulatory Infusion Site	

HealthPartners Preferred Drug List (Formulary), Prior Approval, and Medical Coverage Criteria are available at www.healthpartners.com

Last updated 10/26/2023