Neighborhood Health Plan OF RHODE ISLAND™

General Authorization form for medications administered in office

Tel. 401-427-8200; Fax 844-639-7906

General Prior Authorization for Drugs Administered in Office, fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:

REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

PREVIOUS THERAPIES					
Drug name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Description of failure

Provide rationale for request (submit any pertinent clinical documentation or relevant lab values):

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Requesting Provider:	Date:

Authorization is not a guarantee of payment. Member must be eligible at time of service.