

# Bravo Health

Coverage Review / Prior Authorization Request Form

## Injectable Medications

(antibiotics, IVIG, Remicade, other injectable medications)



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	
Diagnosis and Medication Requested			
Medication Requested (dosage, frequency):		Qty:	Length of Therapy:
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:	
Clinical Criteria			
<b>Please answer the following questions:</b>			
1. Where will this medication be administered? Home      Physician's Office      Outpatient Clinic      LTC			
2. Who will administer the medication? Physican      Home Care Nurse      Patient or Caregiver			
3. How is this medication being administered? IV Push      IM      Sub-Q      IV (disposable pump or gravity)      Infusion pump (external)			
Additional Comments/Explanation:			
<b>*<u>Failure to provide adequate data could result in denial of this request.</u></b>			
Request for Expedited Review			
<input type="checkbox"/>	<b>REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION</b>		

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fax back to: 866-464-0709      For info call: 877-813-5595  
For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>