ambetter. FROM sunflower health plan
Insured by Celtic Insurance Company

Biopharmacy Medication Request Form

Fax to: 888-453-4756

This form is for home health and office injections or infusions.
For questions, call 844-518-9505.

☐ **Standard Request -** Determination within 15 calendar days of receiving all necessary information.
☐ **Urgent Request -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X_____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY

MEMBER INFORMATION	**PRESCRIBER INFORMATION**
Member ID #	Name
First Name	Specialty
Last Name	NPI #
Date of Birth	Group or Hospital
Street Address	Street Address
City, State, Zip	City, State, Zip
	Phone
	Fax
	Contact Name

SERVICING PROVIDER/MEDICATION SUPPLIER (choose from the options below)

☐ **Pharmacy** (Do NOT Use This Form) ☐ **Dispense from Office, Hospital, Outpatient Center Stock** ☐ **Other**

A. Location Name	
B. Location NPI	
C. Phone	D. Contact Name

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
ID Number:	ID Number:
Phone Number:	Phone Number:

DIAGNOSIS

Diagnosis Date:	Diagnosis:	ICD10:

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION. *NOTE: Include diagnostic clinicals (labs, radiology,etc.). For Chemotherapy Medication Requests, include Regimen and Anticipated Dates of Service*

MEDICATION HISTORY

A. Is the member currently treated with this medication?
☐ YES; How long? [go to item B] ☐ NO [skip items B & C; go to item D]

B. Is this request a continuation of a previous approval by Sunflower Health Plan?
☐ YES [go to item C] ☐ NO [skip item C; go to item D]

C. The strength, dosage, or quantity required per day has:
☐ INCREASED [go to item D] ☐ DECREASED [go to item D] ☐ REMAINED THE SAME [go to item D]

D. Indicate PREVIOUS medications treatment/outcomes below.

Drug Name, Strength, and Dosage	**Dates of Therapy**	**Reason for Discontinuation**
1.		
2.		
3.		

MEDICATION REQUESTED (NOTE: You must list the package size NDC for claim or the request will be returned.)

Medication Name/ NDC/JCODE	Dosage/ Strength:
Quantity:	Directions:
Refills:	Start & End Date:

Prescriber's Signature:_____ Date: _____