HIGHMARK WHOLECARE

Home Infusion Request Form

Member Name: _____

Member ID: _____ DOB: _____

Height: _____ Weight: __

Medication: _____ NDC: __

Dose and Frequency: _____

Diagnosis: _____ ICD 10 code: _____

Therapy Start Date: _____ Therapy End Date: _____

Admin Type (pump, gravity, injection, etc): _____

If being administered via pump, is the pump implanted or external? _____

Is the drug being obtained through a pharmacy or through the medical benefit?

Pharmacy – Pharmacy Name & phone number: _____

☐ Medical ("buy and bill") – JCODE: _____

☐

Contact Person: _____ Contact Phone: _____

Prescriber's Full Name: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Address: _____

Prescriber Signature: _____

Any questions, please call:
PA Medicaid 1-800-392-1147
PA Medicare Assured 1-800-685-5209

Fax completed information to:
1-888-245-2049 (Medicaid)
1-888-447-4369 (Medicare Assured)

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