



## PART B MEDICATION REQUEST FORM

Submit this completed form by fax to **1-833-610-2399**, or on our provider portal:  
<https://secure.healthx.com/LagniappeAdvantage.Provider>  
 Call 1-844-217-0052 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless it is an emergency, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

- Routine/Standard       Serious jeopardy to the member’s life or health or ability to regain maximum function

MEMBER INFORMATION		
Member Name:	Member ID:	
Date of Birth:	Member Living Facility:	
REQUESTING PROVIDER/FACILITY		
Requestor’s Name (Print):	Phone Number:	Fax Number:
Referring Provider (If other than requestor):	Referring Provider: <input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other	
NPI/PIN number:	Date of Request:	
SERVICING PROVIDER/FACILITY		
Admitting/ Servicing Facility/ Provider Name:		
NPI/ PIN Number:	Phone Number:	Fax number:
Address:		
City:	State:	Zip:
MEDICATION REQUESTED		
<input type="checkbox"/> Initial Request <input type="checkbox"/> Extension Request, Previous Auth #:		
Place of service: <input type="checkbox"/> Home Infusion <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Specialty Pharmacy		
Specialty Pharmacy:	Home Infusion:	
Days/ Visits/ Units Requested:	Date of Service:	
HCPCS Code(s):	CPT/Other billing code:	
Drug requested:	NDC:	
Dosage:	Frequency/Duration:	
Current Primary Diagnoses and ICD-10 Code (s):		

**CLINICAL INFORMATION**

- Please submit written documentation from the medical record to support the procedure, including photos when applicable.
- Missing this information may delay the decision on your request or may result in Lack of Information denial.
- Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, et

**OUT-OF NETWORK SERVICES ONLY**

- Has the service been scheduled already? Yes No
- Is this a specialized service that no other In-network provider can render? Yes No
- Does the member have an established relationship with the provider that should not be interrupted? Yes No

If "Yes", explain (include last visit date):

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