HCPCS (Healthcare Common Procedure Coding System) Authorization Form

(form effective 11/2022)

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Fax to PerformRx at **1-844-470-2508.** Send urgent faxes to **1-844-470-2511.**
To speak to a representative, call **1-877-472-7979**.

Confidential information

Patient name:		
Patient date of birth (MM/DD/YYYY): / /	Patient ID number:	
Physician name:	Physician Tax ID:	Specialty:
Phone:	Fax:	Physician NPI:
Physician street address:		
City:	State:	ZIP code:
Facility name:	Facility NPI:	
Facility street address:	Facility Tax ID:	
Facility city:	State:	ZIP code:
Treatment setting: ☐ Infusion Center ☐ Home ☐ Provider's Office ☐ Hospital Outpatient Facility		
Medication name and strength requested:	J-code: Number of units: Date of service (MM/DD/YYYY): / /	
Directions:		
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Medication name and strength requested:	J-code: Number of units: Date of service (MM/DD/YYYY): / /	
Directions:		
Anticipated length of therapy: ☐ days ______ ☐ 3 months ☐ 6 months		
Diagnosis:		

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Preferred medications tried/previous therapy. Please include strength, frequency, and duration. (If medications were tried prior to enrollment or if office samples were given, please include chart notes and/or sample logs.)	
Rationale and/or additional information that may be relevant to the review of this prior authorization request. (If more space is needed, please attach an additional page to this document.)	
Physician signature:	Date (MM/DD/YYYY): / /