TUALITY HEALTHCARE *An OHSU Partner* Tuality Hematology Oncology/Infusion clinic Phone:503-681-1064 Fax: 503-681-4120 AMBULATORY INFUSION ORDER **Prior Authorization Form**	PATIENT NAME: BIRTHDATE: Page 1/1
****THIS IS NOT AN ORDER****	

A Prior Authorization for each medication to be administered at Tuality Out-Patient Infusion Services must be obtained by the provider's office

This completed form and a copy of the prior authorization letter (if available) must accompany all orders sent to Tuality out-patient infusion

Please fax all required documents to 503-681-4120

Tuality Out-Patient Infusion Services will review all orders and Prior Authorization documents before scheduling patients for treatment

Medication requested (one medication per form)

Name of medication/ strength /route / direction of medication:

_____

Diagnosis ICD-10 code: _____Diagnosis description: _____

Medication J-code:_____Procedure CPT code:_____

Insurance/PA information

Insurance name/phone number/contact person:

_____

Has been approved- PA #: _____Approval period: Start date_____End Date_____

Has been denied. Reason:_____

No Prior authorization needed (mark with an "X")_____

Prior authorization verification

PA verified by:_____ Provider's office:_____

Providers name: _____ Phone number: _____