



## Physician Administered J-Code Medications Prior Authorization Request

**For PACE and Dual eligible FC Partnership Members ONLY**

**For Family Care (LTC) members call 1-866-937-2783 and ask to speak to the member's care team about authorization requirements. CCI UM does not review or authorize any services for the CCI Family Care (LTC).**

Please complete the PA form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, Phone: 262-207-9393 please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

<b>This form is ONLY needed for the Physician Administered Medications/Codes requiring UM review (listed below)</b>		
<b>As required for all other Physician Administered Medications/Codes, please call member's team @ 1-866-937-2783, # 3</b>		
<input type="checkbox"/> J0585 onabotulinumtoxinA (Botox)	<input type="checkbox"/> J0586 abobotulinumtoxinA (Dysport)	<input type="checkbox"/> J0587 rimabotulinumtoxinB (Myobloc)
<input type="checkbox"/> J0588 incobotulinumtoxinA (Xeomin)	<input type="checkbox"/> J0896 luspatercept	<input type="checkbox"/> J01561 immune globulin
<input type="checkbox"/> J1745 infliximab	<input type="checkbox"/> J2350 ocrelizumab	<input type="checkbox"/> J9022 atezolizumab
<input type="checkbox"/> J9173 durvalumab	<input type="checkbox"/> J9228 ipilimumab	<input type="checkbox"/> J9271 pembrolizumab
<input type="checkbox"/> J9299 nivolumab	<input type="checkbox"/> J9305 pemetrexed	<input type="checkbox"/> J9306 pertuzumab
<input type="checkbox"/> J9312 rituximab	<input type="checkbox"/> J9355 trastuzumab	

Member Name:	D.O.B:	Medicare ID #: Medicaid ID #:
Member Phone:	Member Address:	
Requesting Provider Name/Clinic:		
Address:		
Clinical Contact/Title:	Phone Number:	Fax Number:
Servicing Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contract/Title:	Phone Number:	Fax Number:

**Privacy and confidentiality:**

The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 262-207-9393 (phone) or 414-384-8272 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

205 Bishops Way, Brookfield, WI 53005 • Phone: 262-207-9393 • Fax: 414-384-8272



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Request Type	
<input type="checkbox"/> Standard <input type="checkbox"/> Expedited	Expedited is defined as: Care and services that provide the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.
Please explain rationale for the urgency:	

Diagnosis Information				
Diagnosis or Symptom Information:				ICD-10:
HCPCcode:	Description:	Qty/Freq:	Start Date:	End Date:
HCPCcode:	Description:	Qty/Freq:	Start Date:	End Date:
HCPCcode:	Description:	Qty/Freq:	Start Date:	End Date:

Please complete the following and include supporting documentation with this request:
List previous medication trials for this indication: Please provide name, dates, or trial dose and reason for failure:
1. _____ (drug) at _____ (dose) On _____ (dates of trial) And the patient failed this therapy because:
2. _____ (drug) at _____ (dose) On _____ (dates of trial) And the patient failed this therapy because:
3. _____ (drug) at _____ (dose) On _____ (dates of trial) And the patient failed this therapy because:
<b>NOTE: IF this is for an off-label use, please provide literature evidence to support the off-label use.</b>

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