IVIG referral

Intravenous immunoglobulin | Immunoglobulin

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

IVIG referral

Intravenous immunoglobulin | Immunoglobulin

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Product / concentration; previous IVIG product and treatment dates; tolerance history.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

IVIG referral

Intravenous immunoglobulin | Immunoglobulin

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist note identifying the exact diagnosis, severity, treatment goal and requested product.
- [ ] For antibody deficiency: pretreatment IgG/IgA/IgM, vaccine-response results and infection history, as applicable.
- [ ] For neurologic / other indications: diagnosis-specific testing, functional scores and prior treatment outcomes.
- [ ] Previous IG product, regimen, tolerance and dated weight; any product-specific supporting records.
- [ ] Renewal: objective response, infection frequency or functional change, current dose and continued need.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

SCIG referral

Subcutaneous immunoglobulin | Immunoglobulin

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

SCIG referral

Subcutaneous immunoglobulin | Immunoglobulin

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Product / concentration; current immunoglobulin regimen; training and administration needs.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- ☐ Signed prescription / treatment orders
- ☐ Clinical notes / diagnosis support
- ☐ Prescriber-directed labs / screening
- ☐ Required product / program enrollment
- ☐ Insurance cards (front and back)
- ☐ Current medication and allergy list
- ☐ Prior authorization / payer records
- ☐ Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

SCIG referral

Subcutaneous immunoglobulin | Immunoglobulin

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Diagnosis and specialist assessment supporting the requested SCIG product and indication.
- [ ] For antibody deficiency: pretreatment immunoglobulins, antibody response and infection history, as applicable.
- [ ] For other indications: diagnostic evidence and prior therapy records required by the exact product / plan.
- [ ] Current IG dose, dates, response and reason for change; administration / training plan and dated weight.
- [ ] Renewal: infection or functional outcomes, adherence, tolerance and continuing clinical need.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Alpha-1 augmentation referral

Alpha-1 proteinase inhibitor | Rare disease & other

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

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02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

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03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

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Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Alpha-1 augmentation referral

Alpha-1 proteinase inhibitor | Rare disease & other

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Requested product; documentation supporting the diagnosis; current augmentation regimen.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Alpha-1 augmentation referral

Alpha-1 proteinase inhibitor | Rare disease & other

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist documentation of AAT deficiency and relevant lung disease; exact augmentation product.
- [ ] Pretreatment serum alpha-1 antitrypsin level with units and lab method, plus phenotype / genotype.
- [ ] Pulmonary function report including post-bronchodilator FEV1; supporting imaging when requested.
- [ ] Dated weight, previous augmentation regimen and smoking history / cessation documentation as applicable.
- [ ] Renewal: documented clinical benefit, adherence, tolerance and current treatment plan.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.

Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Infliximab referral

Infliximab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Infliximab referral

Infliximab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product and route; prior therapy response; induction or maintenance treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- ☐ Signed prescription / treatment orders
- ☐ Clinical notes / diagnosis support
- ☐ Prescriber-directed labs / screening
- ☐ Required product / program enrollment
- ☐ Insurance cards (front and back)
- ☐ Current medication and allergy list
- ☐ Prior authorization / payer records
- ☐ Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Infliximab referral

Infliximab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Diagnosis-specific specialist notes: disease activity, severity and relevant examination findings.
- [ ] Objective evidence for the indication: GI studies, joint assessments or skin involvement, as applicable.
- [ ] Prior conventional / biologic treatments: drug, dose, dates, outcome, intolerance or contraindication.
- [ ] Exact product / route, induction history, current weight and clinician-required screening records.
- [ ] Renewal: documented response; clinical rationale and supporting records for any dose / interval change.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Vedolizumab referral

Vedolizumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Vedolizumab referral

Vedolizumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Requested formulation / route; prior therapy response; induction or maintenance treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Vedolizumab referral

Vedolizumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Gastroenterology notes with diagnosis, activity, symptoms and clinical reason for therapy.
- [ ] Available endoscopy / pathology, imaging and inflammatory markers supporting the GI diagnosis.
- [ ] Prior treatments and response, dated trials, intolerance / contraindication, and steroid dependence if relevant.
- [ ] Exact IV or SC formulation, induction dates and maintenance plan; current therapy / screening records.
- [ ] Renewal: symptom / objective improvement, steroid use and rationale for continued treatment.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Ustekinumab referral

Ustekinumab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Ustekinumab referral

Ustekinumab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product and route; indication; induction or maintenance treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Ustekinumab referral

Ustekinumab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist note identifying the indication, severity and exact requested product / formulation.
- [ ] GI: diagnostic studies and activity; skin: body areas / severity; joint disease: clinical activity, as applicable.
- [ ] Previous therapies with doses, dates, outcomes and reasons preferred alternatives are unsuitable.
- [ ] Induction versus maintenance history, dated weight and clinician-required pretreatment screening.
- [ ] Renewal: improvement in the relevant disease measures and continued need for the prescribed regimen.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Risankizumab referral

Risankizumab-rzaa | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Risankizumab referral

Risankizumab-rzaa | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Requested formulation / route; indication; induction or maintenance treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Risankizumab referral

Risankizumab-rzaa | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist diagnosis, disease activity and exact indication for the requested formulation.
- [ ] GI studies, skin severity / affected areas, or joint findings relevant to the patient's indication.
- [ ] Prior systemic / biologic treatments with dates, response, intolerance or contraindication.
- [ ] Induction and maintenance plan; screening and monitoring documentation required for the indication.
- [ ] Renewal: objective or symptom response, current regimen and explanation of requested changes.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Abatacept referral

Abatacept | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Abatacept referral

Abatacept | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Requested formulation / route; previous therapy response; current treatment schedule.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Abatacept referral

Abatacept | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Rheumatology / relevant specialist assessment documenting diagnosis, activity and clinical severity.
- [ ] Indication-specific objective support: joint findings, disease activity measures and diagnostic labs.
- [ ] Previous DMARD / biologic trials with dose, dates, response and contraindications or intolerance.
- [ ] Exact IV or SC formulation, current weight if relevant, concomitant medications and required screening.
- [ ] Renewal: documented disease improvement, tolerability and continuing treatment plan.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Tocilizumab referral

Tocilizumab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Tocilizumab referral

Tocilizumab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product and route; indication; previous therapy response and current treatment schedule.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- ☐ Signed prescription / treatment orders
- ☐ Clinical notes / diagnosis support
- ☐ Prescriber-directed labs / screening
- ☐ Required product / program enrollment
- ☐ Insurance cards (front and back)
- ☐ Current medication and allergy list
- ☐ Prior authorization / payer records
- ☐ Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Tocilizumab referral

Tocilizumab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist notes specifying the exact indication and severity; requested product and route.
- [ ] Indication-specific diagnostic evidence and baseline disease activity / inflammatory findings.
- [ ] Previous therapies, adequate trial dates and outcomes; reasons alternatives are inappropriate.
- [ ] Prescriber-directed screening / monitoring records, such as TB, blood counts and liver tests, as applicable.
- [ ] Renewal: clinical response, current regimen, concomitant therapies and relevant monitoring results.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Rituximab referral

Rituximab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Rituximab referral

Rituximab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product; indication; previous course dates and tolerance; prescribed cycle details.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Rituximab referral

Rituximab products | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist notes confirming the exact indication, clinical severity and requested product.
- [ ] Indication-specific diagnostic reports and baseline disease measures supporting medical necessity.
- [ ] Previous treatments, dose / duration / response; previous rituximab courses and reason for retreatment.
- [ ] Clinician-required screening, including hepatitis B records where applicable, and prescribed monitoring.
- [ ] Renewal: objective treatment response, course dates, tolerance and rationale for another course.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Belimumab referral

Belimumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Belimumab referral

Belimumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Requested formulation / route; prior therapy response; current treatment schedule.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- ☐ Signed prescription / treatment orders
- ☐ Clinical notes / diagnosis support
- ☐ Prescriber-directed labs / screening
- ☐ Required product / program enrollment
- ☐ Insurance cards (front and back)
- ☐ Current medication and allergy list
- ☐ Prior authorization / payer records
- ☐ Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Belimumab referral

Belimumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist confirmation of the lupus indication, activity and relevant organ involvement.
- [ ] Autoantibody results and disease activity documentation; renal studies for nephritis when applicable.
- [ ] Current standard therapy and prior treatment trials, with dates, response or contraindication.
- [ ] Requested IV or SC product, clinical reason for therapy and prescriber-required safety records.
- [ ] Renewal: improvement in lupus activity / relevant organ measures and continuing standard therapy.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Anifrolumab referral

Anifrolumab-fnia | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Anifrolumab referral

Anifrolumab-fnia | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Requested product / formulation; previous therapy response; current treatment schedule.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Anifrolumab referral

Anifrolumab-fnia | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Rheumatology assessment documenting active SLE, severity and organ involvement.
- [ ] Autoantibody / diagnostic results and a baseline disease activity assessment, as required by the plan.
- [ ] Current standard lupus therapy and prior trials with response, intolerance or contraindications.
- [ ] Exact formulation; relevant infection / safety assessment and concomitant medication record.
- [ ] Renewal: change in disease activity, symptoms or steroid use and documented continued clinical benefit.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.

Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Golimumab referral

Golimumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Golimumab referral

Golimumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product and route; indication; prior therapy response and current treatment schedule.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Golimumab referral

Golimumab | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist diagnosis and severity; specify Simponi versus Simponi Aria and the intended route.
- [ ] Disease-specific evidence, such as joint findings, diagnostic labs or GI studies, as applicable.
- [ ] Prior DMARD / biologic trials and concomitant therapy; dose, duration, outcomes and contraindications.
- [ ] Prescriber-required screening and dated weight when relevant; initial versus maintenance regimen.
- [ ] Renewal: clinical response, tolerance and rationale for ongoing therapy or regimen changes.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Ocrelizumab referral

Ocrelizumab-based products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

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Referral contact / direct phone

Referral date / requested start date

Ocrelizumab referral

Ocrelizumab-based products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product and route; previous treatment dates; prior disease-modifying therapies and tolerance.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Ocrelizumab referral

Ocrelizumab-based products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Neurologist assessment specifying MS subtype, course and relevant functional / relapse history.
- [ ] Diagnostic records, including MRI findings and other support for the MS diagnosis when requested.
- [ ] Prior disease-modifying therapies, dates, response and reasons for discontinuation / transition.
- [ ] Exact formulation, last treatment date and clinician-required screening / vaccination documentation.
- [ ] Renewal: disease activity / functional change, current treatment response and medication reconciliation.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Natalizumab referral

Natalizumab products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Natalizumab referral

Natalizumab products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product; program / enrollment documentation applicable to that product; prior treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Natalizumab referral

Natalizumab products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist note specifying the indication, disease activity and exact natalizumab product.
- [ ] Indication-specific diagnostics (MS or GI), prior therapies and documented response / intolerance.
- [ ] Applicable product program / REMS enrollment documentation and authorized administration arrangements.
- [ ] Prescriber risk assessment and monitoring records, including JCV-related records when applicable.
- [ ] Renewal: response, treatment dates, concomitant medication review and current program requirements.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Efgartigimod referral

Efgartigimod-based products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Efgartigimod referral

Efgartigimod-based products | Neurology

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Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product and route; indication; current treatment cycle and previous treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Efgartigimod referral

Efgartigimod-based products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Neurologist diagnosis, exact product / route and the indication-specific treatment rationale.
- [ ] gMG: baseline severity / MG-ADL and antibody records as requested; verify current product / plan criteria.
- [ ] CIDP, when applicable: diagnostic / electrodiagnostic support and baseline functional measures.
- [ ] Previous therapies with dates / outcomes, current regimen and clinician-directed safety records.
- [ ] Renewal: comparable symptom / functional scores, response by cycle and rationale for continued use.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
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- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

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Authorization valid from / through

Approved units / visits / frequency

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Outstanding items / N/A rationale / reviewer and date

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Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Ravulizumab referral

Ravulizumab-cwvz | Rare disease & other

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

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03 REFERRING CLINICIAN

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Referral date / requested start date

Ravulizumab referral

Ravulizumab-cwvz | Rare disease & other

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Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Indication; prior complement-inhibitor treatment; applicable program and prescriber-directed records.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

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Prepared by / role / direct phone

Date completed

Ravulizumab referral

Ravulizumab-cwvz | Rare disease & other

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Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist note identifying the exact indication, severity and reason for complement-inhibitor treatment.
- [ ] Indication-specific support: PNH flow cytometry / hemolysis; aHUS workup; or relevant neurologic antibodies.
- [ ] Previous treatments, current weight, last complement-inhibitor dose and transition / maintenance plan.
- [ ] Applicable REMS / enrollment, meningococcal vaccination and prescriber-directed prevention records.
- [ ] Renewal: indication-specific response (labs, organ function or clinical scores) and continued need.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

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Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

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Outstanding items / N/A rationale / reviewer and date

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Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Eculizumab referral

Eculizumab products | Rare disease & other

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

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Weight (kg) / date measured

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02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

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03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

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Office phone

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Referral contact / direct phone

Referral date / requested start date

Eculizumab referral

Eculizumab products | Rare disease & other

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Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product; indication; prior treatment dates; applicable program and prescriber-directed records.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

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Date completed

Eculizumab referral

Eculizumab products | Rare disease & other

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Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist diagnosis, exact product and documented disease severity / medical necessity.
- [ ] Diagnosis-specific evidence: PNH testing; aHUS workup; or neurologic diagnostic / antibody records.
- [ ] Previous therapies with dated outcomes, current weight and prior complement-inhibitor treatment.
- [ ] Applicable product REMS / enrollment, meningococcal vaccination and prevention documentation.
- [ ] Renewal: objective response, current dosing history and ongoing clinical need for the exact product.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Edaravone referral

Edaravone products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Edaravone referral

Edaravone products | Neurology

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Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Exact product and route; prescribed cycle; previous treatment dates and administration needs.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Edaravone referral

Edaravone products | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] ALS specialist / neurologist assessment and diagnostic evidence supporting definite or probable ALS.
- [ ] Baseline ALSFRS-R with dated item scores; respiratory / ventilatory status and requested supporting tests.
- [ ] Clinical history and prior / current ALS treatments with dates, response and tolerance.
- [ ] Exact formulation and route; prescribed cycle, last treatment dates and administration needs.
- [ ] Renewal: clinical benefit, functional / respiratory status and continuing plan; verify route-specific policy.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Eptinezumab referral

Eptinezumab-jjmr | Neurology

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Eptinezumab referral

Eptinezumab-jjmr | Neurology

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Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Previous preventive therapies and response; current treatment schedule and previous treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Eptinezumab referral

Eptinezumab-jjmr | Neurology

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Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Migraine diagnosis with baseline headache days and migraine days per month, supported by dated records.
- [ ] Prior preventive medicines: dose, trial duration, response, intolerance or contraindication.
- [ ] Current preventive and acute medications; prior CGRP / botulinum therapy and transition plan if relevant.
- [ ] Prescriber assessment of functional burden and reason for requested product / regimen.
- [ ] Renewal: change in migraine frequency or severity and documented benefit compared with baseline.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

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Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Teprotumumab referral

Teprotumumab-trbw | Rare disease & other

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

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Secondary plan / member ID

Prescription plan / member ID

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Referral date / requested start date

Teprotumumab referral

Teprotumumab-trbw | Rare disease & other

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Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Prescriber assessment; prior treatment dates; current course and prescriber-directed monitoring records.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

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Prepared by / role / direct phone

Date completed

Teprotumumab referral

Teprotumumab-trbw | Rare disease & other

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Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist TED diagnosis and activity / severity assessment; document chronic or active disease.
- [ ] Eye findings: proptosis, diplopia, soft-tissue changes or clinical activity score, as applicable.
- [ ] Thyroid function / management and prior TED treatments; number and dates of previous infusions.
- [ ] Prescriber-directed baseline / monitoring records, including hearing and glucose assessment as applicable.
- [ ] Continuation: treatment response and planned remaining course; verify payer lifetime / retreatment limits.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
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Payer / plan / policy version / verification date

Authorization number / payer reference

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Approved units / visits / frequency

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Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Pegloticase referral

Pegloticase | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

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State / ZIP

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02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Pegloticase referral

Pegloticase | Autoimmune & GI

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Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Previous therapies and response; current treatment dates; concomitant therapy and monitoring orders.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Pegloticase referral

Pegloticase | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Chronic refractory gout diagnosis with flares, tophi or gout-related joint damage documented.
- [ ] Dated serum urate results and prior urate-lowering trials with doses, duration and response / intolerance.
- [ ] Prescriber safety records, including G6PD status where applicable, and planned monitoring.
- [ ] Concomitant immunomodulator plan or clinical reason for omission; previous pegloticase dates.
- [ ] Renewal: serum urate trend, clinical response, tolerance and continued treatment rationale.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Omalizumab referral

Omalizumab | Allergy & asthma

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Omalizumab referral

Omalizumab | Allergy & asthma

Review draft only. Not a standalone prescription or administration protocol.
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Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Indication; prescribed product / device; prior treatment response and administration setting.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Omalizumab referral

Omalizumab | Allergy & asthma

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Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist diagnosis and indication-specific severity; verify the exact product / formulation.
- [ ] For asthma / polyps / food allergy: IgE, weight and diagnostic testing as applicable to the indication.
- [ ] For urticaria: symptom duration / severity and prior antihistamine trials; other indications use their criteria.
- [ ] Prior / current therapies, dates and outcomes; exacerbation history or allergic-event history as relevant.
- [ ] Renewal: indication-specific improvement, adherence and continued need; administration plan documented.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
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Authorization valid from / through

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Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Dupilumab referral

Dupilumab | Allergy & asthma

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

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02 COVERAGE INFORMATION

Primary insurance plan

Member ID

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Policyholder name / DOB / relationship

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Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Dupilumab referral

Dupilumab | Allergy & asthma

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Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Indication; prescribed product / device; prior treatment response and injection training needs.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Dupilumab referral

Dupilumab | Allergy & asthma

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Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist documentation of the exact indication, severity and requested device / formulation.
- [ ] For dermatitis: affected body areas, severity / functional burden and prior topical / systemic treatments.
- [ ] For other indications: obtain the current payer criteria and diagnosis-specific studies / clinical measures.
- [ ] Previous therapy doses, durations, response and reasons alternatives are unsuitable; current therapy list.
- [ ] Renewal: indication-specific improvement and continued need; dose and device match the patient / order.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
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Therapy policy example (click to open)
CMS drug billing guidance (click to open)

Mepolizumab referral

Mepolizumab | Allergy & asthma

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01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

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Prescriber name / credentials

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Office phone

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Mepolizumab referral

Mepolizumab | Allergy & asthma

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Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Indication; prescribed product / device; prior treatment response and administration setting.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

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Mepolizumab referral

Mepolizumab | Allergy & asthma

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Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist diagnosis and severity; specify the indication and exact product / device.
- [ ] For eosinophilic asthma: dated eosinophil counts, exacerbations, steroid use and controller regimen.
- [ ] For other indications: diagnosis-specific evidence (e.g., nasal findings, EGPA / HES workup) per payer policy.
- [ ] Previous therapies, doses, dates and outcomes; current medications and required exclusion workup.
- [ ] Renewal: clinical improvement, exacerbation / steroid trend or other indication-specific response.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

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