Physician Administered J-Code Medications Prior Authorization Request

For PACE and Dual eligible FC Partnership Members ONLY

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

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

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

This form is ONLY needed for the Physician Administered Medications/Codes requiring UM review (listed below) **As required for all other Physician Administered Medications/Codes, please call member's team @ 1-866-937-2783, # 3**		
☐ J0585 onabotulinumtoxinA (Botox)	☐J0586 abobtulinumtoxinA (Dysport)	☐J0587 rimabotulinumtoxinB (Myobloc)
☐ J0588 incobotulinumtoxinA (Xeomin)	☐J0589 daxibotulinumtoxina-lanm	☐J0896 luspatercept
☐ J1561 immune globulin	☐J1745 infliximab	☐J2350 ocrelizumab
☐ J9022 atezolizumab	☐J9173 durvalumab	☐ J9228 ipilimumab
☐ J9271 pembrolizumab	☐J9299 nivolumab	☐J9305 pemetrexed
☐ J9306 pertuzumab	☐J9312 rituximab	☐ J9355 trastuzumab
☐ J3247 secukinumab (Cosentyx)	☐	

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

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

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

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

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