THE OHIO STATE UNIVERSITY
HEALTH PLAN

HOME INFUSION/ENTERAL THERAPY AUTHORIZATION FORM

Instructions: Please print all requested information and submit this form with physician order to OSU Health Plan via email at: UtilizationManagement.OSUHealthPlan@osumc.edu or fax to: 614-292-2667. Contact an OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance in completing the entire form.

** See page 2 for infusion(s) codes. Use the same codes listed in your contract and on invoice to Trustmark when completing this form**

PATIENT INFORMATION: PRINT all information requested below:

First Name:_____Last Name:_____DOB:___/___/_____

Insurance ID #:_____Current Diagnosis:_____ICD-10_____; _____

Current/Previous Auth. #_____

Referring Physician Name: _____

Anticipated Dates of Service:_____/_____/_____to ____/_____/_____

Teachable Caregiver: ☐Yes ☐No Homebound: ☐Yes ☐ No ; if no – please explain below:

_____

_____

PROVIDER INFORMATION:

Company Name: _____

Telephone Number: (____)_____-_____ext_____Fax Number: (____)_____-_____

Email Address:_____

Contact Name:_____Telephone Number: (____)_____-_____ext_____

REQUESTED SERVICES: ☐ Infusion Nursing **CODE 99601** (up to 2 hour visit) _____ visits requested.

☐ Infusion Nursing **CODE 99602** (3 hours or more) _____ visits requested.

TO BE COMPLETED BY OSU Health Plan

On Date:_____Services are:

☐ Approved as requested

☐ Partial approval as noted: _____

☐ Denied with reason: _____

Additional Comments: _____

Authorization #:_____Authorized by:_____, RN

Phone #: (614)_____ Email Address: _____

IV Drug *(include dose, frequency, and daily units)*	**# Units/day/month**
J0170 EPINEPHRINE INJ.	
J0878 CUBICIN 1 MG	
J1335 INVANZ	
J0696 CEFTRIAXONE SODIUM 250 MG	
J0690 CEFAZOLIN SODIUM 500 MG	
J0692 CEFEPIME 500 MG	
J2543 PIPERACILLIN/TAZOBACTAM SODIUM 1.125 GRAM	
J3370 VANCOMYCIN 500 MG	
J2930 SOLUMEDEROL 1 GRAM	
J1745 REMICADE (INFLIZIMAB) 10 MG	
J3380 ENTYVIO (VEDOLIZUMAB) 1 MG	
J2405 ZOFRAN 1 MG	
J9190 FLUOROURACIL (5FU) 500 MG	
J1200 DIPHENHYDRAMINE HCL UP TO 50 MG	
J2997 ACTIVASE 1MG/ALTEPLASE RECOMBINANT DECLOTTING	
A4216 STERILE NORMAL SALINE FLUSH 10 CC	
J1642 HEPARIN SODIUM FLUSH PER 10 UNITS	
J7030 NORMAL SALINE INFUSION 1000 ML	

PER DIEM	**# Units/day/month**
S5501 CATH CARE > 1 LUMEN	
S5498 CATH CARE SINGLE LUMEN	
S9500 ANTIBIOTIC Q24 HR	
S9501 ANTIBIOTIC Q 12HR	
S9502 ANTIBIOTIC Q 8HR	
S9503 ANTIBIOTIC Q 6HR	
S9330 CONTINUOUS CHEMO	
S9340 ENTERAL PER DIEM	
S9343 ENTERAL BOLUS PER DIEM	
S9374 HYDRATION 1 LITER	
S9376 HYDRATION 2 - 3 LITERS	
S9377 HYDRATION > 3 LITERS	
S9490 CORTICOSTEROID	
S9365 TPN 1 LITER	
S9366 TPN 1 – 2 LITERS	
S9367 TPN 2 – 3 LITERS	
S9368 TPN > 3 LITERS	

Enter misc/other IV drug/TPN/Enteral Code(s) Below: *(include dose, frequency, and daily units)*	**# Units/day/month**