MEDI-CAL TAR FORM:
TREATMENT AUTHORIZATION REQUEST FOR PROVIDER ADMINISTERED DRUG SERVICES (PAD)

Drugs administered directly to a member at a medical site of care

①Print Blank ②Complete ③Sign ④FAX

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4414 or (800) 863-4155
FAX # (707) 863-4330
www.partnershiphp.org

(PLEASE TYPE) (FOR PROVIDER USE) (PLEASE TYPE)

IS REQUEST RETROACTIVE (Service already provided)? YES: ☐ NO: ☐

NON-RETRO ONLY: IS REQUEST MEDICALLY URGENT? YES: ☐ NO: ☐

If multiple provider locations, enter the location where services for the member are provided

PROVIDER NAME & ADDRESS:

-
-
-
-

PROVIDER NPI:

PHC PROVIDER NUMBER:

PROVIDER PHONE, WITH AREA CODE:

PROVIDER FAX #, WITH AREA CODE:

MEMBER NAME (LAST, FIRST, MI) & CONTACT INFO:

STREET ADDRESS

CITY, STATE, ZIP

PHONE NUMBER, WITH AREA CODE

MEMEBER IDENTIFICATION NO.

SEX AGE MO/YR DATE OF BIRTH (MM/DD/YYYY)

WEIGHT

CHEMOTHERAPY TARS: BSA required

MEMBER'S AUTHORIZED REPRESENTATIVE (IF ANY) -- NAME AND CONTACT INFORMATION:

Name
Relationship
Street
City, State Zip
Phone

PLACE OF SERVICE (WHERE MEDICATION IS TO BE ADMINISTERED)

☐ OUTPATIENT INFUSION CENTER other than pharmacy-based (ie, no PBM billing available) ☐ OUTPATIENT HOSPITAL ☐ MEDICAL OFFICE or CLINIC ☐ DIALYSIS CENTER OTHER:

PRIMARY DIAGNOSIS; SECONDARY IF RELEVANT	ICD-10	ADDITIONAL RELEVANT DIAGNOSIS	ICD-10

MEDICAL JUSTIFICATION: Disease activity/stage, history/results of other treatments tried, allergies/intolerance/contraindications relevant to treatment selection, lab results, and other information as required by PHC criteria or to to support medical necessity. Attach additional sheets to the TAR submission if needed.

INJECTION SITE IF APPLICABLE (EG, R/L/B AFFECTED JOINT, LIMB, ETC): _____

NO.	SERVICE CODE	DRUG SERVICE (svc) DESCRIPTION	NDC: *REQUIRED FOR J3490, J3590*	DOSE (in mg, mcg, g)	HOW OFTEN (eg, Q8h, Q7d)	SVC QTY (Total doses)	TX DURATION (eg, wks, mo, cycles)
1							
2							
3							
4							
5							
6							

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

REQUESTED AUTHORIZATION PERIOD

START DATE END DATE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBLITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.