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## BioScrip Injectable Drug Program (For St. John Health System *ONLY*)

St. John Health System has partnered with BioScrip to exclusively provide the following injectable medications for SmartHealth Plan.

Medication	Commercial Name	J-Code
Infliximab	Remicade®	J1745
Alglucerase	Ceredase®	J0205
Imiglucerase	Cerezyme®	J1785
Antihemophilic Factors	Factor VII, VIII, IX	J7187 thru J7199
Botulinum A Toxin	Botox®	J0585, J0586, J0587
Intravenous Immunglobulins	IVIG	J1561, J1562, J1566 thru J1569

BioScrip offers the following features:

- Efficient medication authorization and enrollment process using a one-page form.
- Express delivery of medications to physician offices and patient homes.
- Complete product availability and coordinated monthly scheduling of deliveries.
- Customer service support including insurance verification and billing.
- Coordination of medication refills and renewals.
- Patient monitoring and education programs to improve adherence to medications.

**Physicians will be reimbursed for administration/infusion of these drugs only. The above mentioned J-Codes will not be reimbursed to physicians.**

Use the attached BioScrip form to enroll a patient requiring one of these medications. Fax the completed form to BioScrip at (877) 254-3674. BioScrip will verify member eligibility and medication appropriateness. Upon approval, BioScrip will contact you to arrange delivery of the medication.

# BioScrip Injectable Enrollment Form

**bio scrip**

Phone: 1-877-842-5097

Fax: 1-877-254-3674

**Injectable  
Enrollment Form**

PATIENT INFORMATION		
Patient Name	<input type="checkbox"/> Male + Female	Allergies
Date of Birth	SSN#	
Address	City	State Zip
Phone # (home)	(Work)	Email address
Caregiver	Case Manager	
INSURANCE INFORMATION		
Primary Insurance		Policyholder
Group #	Policy #	Phone #
DIAGNOSIS INFORMATION (Please specify primary and secondary diagnoses)		
Primary ICD-9	Secondary ICD-9	
Is patient new to therapy? <input type="checkbox"/> yes <input type="checkbox"/> no Date of diagnosis		
PREVIOUS MEDICATIONS (Please specify dosage & Time on therapy)		
<u>Medication Strength &amp; Dose</u>	<u>Dates of Therapy</u>	<u>Reason for Discontinuing</u>
PRESCRIPTION INFORMATION		
<u>Medication</u>	<u>Dose/Frequency</u>	<u>Quantity Refills</u>
DELIVERY INSTRUCTIONS		
<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Other	Date Medication Needed
<input type="checkbox"/> Patient's Home	Address	
	City/State/Zip	
PHYSICIAN CONTACT INFORMATION & AUTHORIZATION		
Physician Name	Office Contact	Institution
Phone	Fax	E-mail
Address	City/State/Zip	
License #	DEA #	
Physician's Signature _____		
Date _____		
(required to process prescription)	may substitute	may not substitute