



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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

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- ① **Print Blank** ② **Complete** ③ **Sign** ④ **FAX**

(PLEASE TYPE)	(FOR PROVIDER USE)	(PLEASE TYPE)					
IS REQUEST RETROACTIVE (Service already provided)? YES: <input type="checkbox"/> NO: <input type="checkbox"/>		PRESCRIBER NPI:					
NON-RETRO ONLY: IS REQUEST MEDICALLY URGENT? YES: <input type="checkbox"/> NO: <input type="checkbox"/>		ADMINISTERING FACILITY NPI NUMBER:					
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> If multiple provider locations, enter the location where services for the member are provided </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> PROVIDER NAME & ADDRESS: • • • • </div>		PROVIDER PHONE, WITH AREA CODE:					
			PROVIDER FAX #, WITH AREA CODE:				
MEMBER NAME (LAST, FIRST, MI) & CONTACT INFO:	MEMEBER IDENTIFICATION NO.	MEMBER'S AUTHORIZED REPRESENTATIVE (IF ANY) -- NAME AND CONTACT INFORMATION:					
STREET ADDRESS	SEX <input type="checkbox"/> AGE <input type="checkbox"/> MO/YR <input type="checkbox"/> DATE OF BIRTH (MM/DD/YYYY) <input type="text"/>	Name					
CITY, STATE, ZIP	WEIGHT <input type="text"/> CHEMOTHERAPY TARS: BSA required <input type="checkbox"/>	Relationship					
PHONE NUMBER, WITH AREA CODE		Street					
		City, State Zip					
		Phone					
PLACE OF SERVICE (WHERE MEDICATION IS TO BE ADMINISTERED)							
	<input type="checkbox"/> OUTPATIENT INFUSION CENTER other than pharmacy-based (ie, no PBM billing available)	<input type="checkbox"/> OUTPATIENT HOSPITAL <input type="checkbox"/> MEDICAL OFFICE or CLINIC <input type="checkbox"/> DIALYSIS CENTER <input type="text"/> OTHER:					
PRIMARY DIAGNOSIS; SECONDARY IF RELEVANT	ICD-10	ADDITIONAL RELEVANT DIAGNOSIS					
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 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: <small>REQUIRED FOR J3490, J3590</small>	DOSE <small>(in mg, mcg, g)</small>	HOW OFTEN <small>(eg, Q8h, Q7d)</small>	SVC QTY <small>(Total doses)</small>	TX DURATION <small>(eg, wks, mo, cycles)</small>
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.					REQUESTED AUTHORIZATION PERIOD START DATE END DATE <input style="width: 100px; height: 20px;" type="text"/> <input style="width: 100px; height: 20px;" type="text"/>		
SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE							

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