



Gateway Health Plan[®] Home Infusion Request Form

Patient Name: _____

GHP ID#: _____ DOB: _____

Pharmacy Name: _____

Contact Person: _____ Phone: _____

Drug: _____ DX Code: _____

Dose and Frequency: _____

Nursing: _____ How many: _____

Supply Code(s): _____ How many: _____

Admin. Type (pump, gravity, injection, etc): _____

Prescribing Doctor's Full Name: _____

Prescribing Doctor's Phone Number: _____

Prescribing Doctor's Fax Number: _____

Start Date: _____ End Date: _____

** Please include **all** orders for medications that **are not** on the covered Home Infusion List.

** Any questions, please call: **1-888-223-5141**.

** Fax completed info to: **1-888-245-2049**.