



**Gateway Health Plan®
Home Infusion Request Form**

Patient Name: _____

Member 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): _____

Prescriber's Full Name: _____

Prescriber's Phone: _____ Prescriber's Fax: _____

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 information to:

**1-888-245-2049 (Gateway Medicaid)
1-888-447-4369 (Gateway Medicare Assured®)**