

# PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: Community Health GroupPlan/Medical Group Phone#: (800) 788-2949Please fax the completed form to **858-790-7100**

<b>Instructions:</b> Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.					
<b>Patient Information: This must be filled out completely to ensure HIPAA compliance</b>					
First Name:		Last Name:		MI:	Phone Number:
Address:			City:	State:	Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____		Allergies:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:		
<b>Insurance Information</b>					
Primary Insurance Name:			Patient ID Number:		
Secondary Insurance Name:			Patient ID Number:		
<b>Prescriber Information</b>					
First Name:		Last Name:		Specialty:	
Address:			City:	State:	Zip Code:
Requestor (if different than prescriber):			Office Contact Person:		
NPI Number (individual):			Phone Number:		
DEA Number (if required):			Fax Number (in HIPAA compliant area):		
Email Address:					
<b>Medication / Medical and Dispensing Information</b>					
Medication Name:					
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal					
If Renewal: Date Therapy Initiated:			Duration of Therapy (specific dates):		
How did the patient receive the medication?					
<input type="checkbox"/> Paid under Insurance    Name: _____			Prior Auth Number (if known): _____		
<input type="checkbox"/> Other (explain): _____					
Dose/Strength:		Frequency:		Length of Therapy/#Refills:	
				Quantity:	
Administration:					
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other:					
Administration Location:		<input type="checkbox"/> Patient's Home		<input type="checkbox"/> Long Term Care	
<input type="checkbox"/> Physician's Office		<input type="checkbox"/> Home Care Agency		<input type="checkbox"/> Other (explain): _____	
<input type="checkbox"/> Ambulatory Infusion Center		<input type="checkbox"/> Outpatient Hospital Care		_____	

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Patient Name:	ID#:
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**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

<b>1. Has the patient tried any other medications for this condition?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO
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Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

<b>2. List Diagnoses:</b>	<b>ICD-9/ICD-10:</b>
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<b>3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization review.</b>
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Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

Attachments

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

I agree to be notified via fax of the prior authorization determination and/or need for additional information at the Prescriber fax listed above.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**Plan Use Only:**                      Date of Decision: \_\_\_\_\_

Approved     Denied    Comments/Information Requested: \_\_\_\_\_