

Pharmacy PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012
Last Updated: January 2011

For Prior Authorization, please fax toll-free (877) 974-4411, or local number (616) 942-8206

Non-covered Medication

- URGENT** (life threatening)
- Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Medication Requested

Strength

Daily Dosage

Anticipated Length of Therapy

Start Date

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION (ALL ITEMS MUST BE COMPLETED):

A. Indication medication is being used for in patient: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. Rationale for use of requested drug product over a preferred (formulary) medication:

C. List similar medications previously used by patient (include chart notes documenting use of medication(s) if the patient tried the medications when s/he was not a Priority Health Member).

Drug Name: _____ Date: _____ Outcome: _____

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FOR MEDICARE ONLY

THE FOLLOWING STATEMENTS ARE APPLICABLE FOR MEDICARE PART D ONLY: If none of the above is applicable to this member, please check which, if any, of the following apply:

All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects

The number of doses available under a dose restriction for the prescription drug:

- Has been ineffective in the treatment of the enrollee's disease or medical condition or,
- Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance

The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:

- Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
- Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

None of the above apply

***** All fields must be complete and legible for Prior Authorization Review***
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**