

Pharmacy Prior Authorization Form

Last Reviewed: Nov. 11

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

This form applies to: Commercial Medicaid Medicare

Vaccines

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Vaccine Requested (please choose one):

- Havrix
- Imovax Rabies Vaccine
- Rabavert
- Recombivax
- Vaqta

Priority Health precertification requirements:

Authorization for Vaccines require:

- Part B benefit
 - The vaccine being provided is directly related to the treatment of an injury or direct exposure to the patient
 - The exposed patient is at significant risk to contract a disease as a result of exposure
 - The vaccine is not a routine immunization
- Part D benefit
 - The vaccine is a routine immunization
 - The vaccine is being provided as preventative means due to possible exposure to the patient

Please Complete the Following Information:

**If any of the three criteria below apply, the vaccine is considered a Medicare Part B benefit.*

- The vaccine being provided is directly related to the treatment of an injury or direct exposure to the patient.
- The exposed patient is at significant risk to contract a disease as a result of exposure.
- The vaccine is not a routine immunization.

**If any of the two criteria below apply, the vaccine is considered a Medicare Part D benefit.*

- The vaccine is a routine immunization.
- The vaccine is being provided as preventative means due to possible exposure to the patient

For Medicare 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**