Priority Health

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Medical Drug authorization request

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____
Physician Address: _____
Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug requested:_____
Strength:_____
Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose (if applicable): _____
Dose:_____ **Dose Frequency**:_____
BSA (if applicable):_____
Weight (if applicable):_____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Agency: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax.
New 10/2018
Reviewed: 01/2024

Priority Health Precertification Documentation

A. List the patient's medical condition the drug is being requested for: _____

B. Explain the medical reason for this request:

_____

_____

_____

C. List previous drugs the patient tried. (List the name, date prescribed, and any other important information.)

Drug name	Strength	Dosing schedule/frequency	Date prescribed	Date stopped

D. **Provide any additional information for consideration** (optional)**:** _____

_____

_____

_____

_____

_____

_____

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New 10/2018
Reviewed: 01/2024