

# Pharmacy 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.

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## Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Product Information

Medication requested: \_\_\_\_\_ Start date (or date of next dose): \_\_\_\_\_

Strength: \_\_\_\_\_ Date of last dose (if applicable): \_\_\_\_\_

Dosing frequency: \_\_\_\_\_

Anticipated length of therapy: \_\_\_\_\_

**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.

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## 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 documentation or information (chart notes, lab records) to support this request:

\_\_\_\_\_  
\_\_\_\_\_