Prior authorization form for medical benefit drugs

Please use this form for prior authorizations that pertain to physician-administered drugs only (including home infusion). **Fax completed form to 1-508-791-5101**. Services are subject to coverage, benefit, network and contract policies and exclusions.

Patient information

Last name: _____ First name: _____ MI: _____

DOB: _____ Fallon Health ID number: _____

Physician information

Physician name: _____ Specialty: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____ NPI: _____

Medication requested (one medication per form)

☐ New request for Fallon ☐ Renewal for Fallon

Name and strength of medication: _____

Directions/frequency of use: _____

Diagnosis ICD-10 code *(required)*: _____

Diagnosis description *(required)*: _____

Expected duration of therapy: _____

Medications or treatments previously used: _____

Reason why patient cannot use Fallon -preferred medications *(formulary available at fallonhealth.org)*:

_____

Notes or relevant lab values: _____

If a renewal, please provide an update on patient status: _____

For medication administered in the office, hospital (outpatient), infusion/dialysis center or home infusion setting, complete the following: JCode: _____ NDC: _____

Rendering provider/facility name and NPI: _____

Product will be obtained from:

☐ Fallon-preferred vendor ☐ MD stock ☐ Above rendering provider *(If not specified, Fallon-preferred vendor will be used. Fallon-preferred vendor information will be provided upon approval.)*

Member-requested pre-service denial

Complete this section only for Fallon Senior Plan™ members when declining to submit a prior authorization for a medication requested by the member. Fallon will notify the submitting physician and member of the determination. **Please provide all information requested.**

1. Medication requested by member: _____
2. Member's reason for request: _____