PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial** ☒ **Medicaid** ☒ **MIChild**

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. The standard review time averages between 1 and 3 business days.

Non-covered Medication

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: _____

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 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 drug's use for the identified indication.

Priority Health Precertification Documentation

A. List the patient's condition: _____

B. What is the medical reason for this request?

_____

_____

_____

C. Previous other drugs did the patient try? (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): _____

_____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2013

Last reviewed 01/2015