



PRIOR AUTHORIZATION FORM

PLEASE FAX COMPLETED FORM TO: (800) 639-9158

*****Please note any information that is incomplete or illegible will delay the review process.*****

| | |
|------------------------------------|---------------------|
| Patient Name: | Member ID # |
| ****Member Phone Number**** | |
| Date of Request: | DOB: |
| Plan ID: | Benefit: |
| Requesting Physician: | DEA # |
| Office Phone # | Office Fax # |
| Office Address: | |
| Tax ID Number: | |

MEDICATION INFORMATION

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|--|
| 1. Drug Requested: (Please include: dose/frequency/length of therapy.) |
| 2. If Injectable medication, where is it being administered? <input type="checkbox"/> Home (self-administered) <input type="checkbox"/> Office administered |
| 3. Diagnosis: (Please include all office notes supporting diagnosis.) |
| 4. Previous agents tried:(Include all office notes and supporting documentation.) Drug: Date(s) used: Outcome: Drug: Date(s) used: Outcome: Drug: Date(s) used: Outcome: Drug: Date(s) used: Outcome: |
| 5. Other Supporting information: |

This section to be used only if requesting an exception to the plan's utilization management requirements. Not completing below means medical exception to the utilization requirement(s) is not needed.
 I have reviewed the requirements and acknowledge that the patient does not meet the plan's specific utilization requirements. However, based upon the reason I will provide below, it is my clinical opinion that my patient should be exempt from meeting the plan's clinical coverage criteria for this medication. **Statement should include specifically which requirement is not met**

For Urgent Requests please call (800) 551-2694

**Visit our Websites at <http://www.firsthealthpartd.com>, <http://www.chcadvantra.com>,
<http://www.summithealthplan.com> and <http://www.vistahealthplan.com>**

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and why patient should be exempt from meeting this requirement.

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Physician's Signature:

Physician's Specialty:

CHCH 2007-1(9/12)

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