

# Medication Prior Authorization Request Form Contact Information



***CoverMyMeds is California Health & Wellness' preferred way to receive prior authorization requests. Visit [go.covermyeds.com/InvolveRx](http://go.covermyeds.com/InvolveRx) to begin using this free service OR FAX this completed form to (866) 399-0929.***

The State of California now requires health plans to use the standardized Prescription Drug Prior Authorization Form 61-211 (attached) for all medication Prior Authorization requests. Please note the contact information differs based on the type of prior authorization request being made.

## **Self-Administered Non-Specialty Medications**

***Involve Pharmacy Solutions***, California Health & Wellness' Pharmacy Benefit Manager, processes pharmacy claims and administers the prior authorization process for self-administered (i.e. oral, self-injectable, topical, ophthalmic) drugs. **For self-administered medications that require a prior authorization use the contact information below:**

### **Involve Pharmacy Solutions**

Prior Authorization Fax: **1-866-399-0929**

Prior Authorization Phone: **1-877-277-0413**

Clinical Hours: Monday – Friday 6 a.m.- 5 p.m. (PST)

Call Center: **1-855-330-2338**

## **Self-Administered Specialty Medications**

For specialty medication requests, please use the contact information below:

### **AcariaHealth**

Prior Authorization Fax: **1-855-217-0926**

Prior Authorization Phone: **1-855-535-1815**

## **Physician-Administered Specialty Medications**

Prior Authorization requests for medications that will be administered by a provider (i.e. biopharmacy, home health, outpatient, injectable or infusible medications), are handled by the California Health & Wellness Pharmacy Department. Please fax these requests to the number below:

### **California Health & Wellness Pharmacy Department**

Prior Authorization Fax: **1-877-259-6961**

Prior Authorization Phone: **1-877-658-0305**

# PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: \_\_\_\_\_

Plan/Medical Group Phone#: (\_\_\_\_) \_\_\_\_\_

Plan/Medical Group Fax#: (\_\_\_\_) \_\_\_\_\_

|  |  |   |   |   |               |
|--|--|---|---|---|---------------|
| <b>Instructions:</b> Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request. |  |   |   |   |               |
| <b>Patient Information: This must be filled out completely to ensure HIPAA compliance</b>  |  |   |   |   |               |
| First Name:  |  | Last Name:  |   | MI:   | Phone Number: |
| Address:   |  |   | City:                                   | State:  | Zip Code:     |
| Date of Birth:   | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Circle unit of measure<br>Height (in/cm): _____ Weight (lb/kg): _____ |   | Allergies:                                      |               |
| Patient's Authorized Representative (if applicable):   |  |   | Authorized Representative Phone Number: |   |               |
| <b>Insurance Information</b>   |  |   |   |   |               |
| Primary Insurance Name:  |  |   | Patient ID Number:                      |   |               |
| Secondary Insurance Name:  |  |   | Patient ID Number:                      |   |               |
| <b>Prescriber Information</b>  |  |   |   |   |               |
| First Name:  |  | Last Name:  |   | Specialty:                                      |               |
| Address:   |  |   | City:                                   | State:  | Zip Code:     |
| Requestor (if different than prescriber):  |  |   | Office Contact Person:                  |   |               |
| NPI Number (individual):   |  |   | Phone Number:                           |   |               |
| DEA Number (if required):  |  |   | Fax Number (in HIPAA compliant area):   |   |               |
| Email Address:   |  |   |   |   |               |
| <b>Medication / Medical and Dispensing Information</b>   |  |   |   |   |               |
| Medication Name:   |  |   |   |   |               |
| <input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal<br>If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____   |  |   |   |   |               |
| How did the patient receive the medication?  |  |   |   |   |               |
| <input type="checkbox"/> Paid under Insurance    Name: _____    Prior Auth Number (if known): _____<br><input type="checkbox"/> Other (explain): _____   |  |   |   |   |               |
| Dose/Strength:   |  | Frequency:  |   | Length of Therapy/#Refills:                     |               |
|  |  |   |   | Quantity:                                       |               |
| Administration:  |  |   |   |   |               |
| <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____   |  |   |   |   |               |
| Administration Location:   |  | <input type="checkbox"/> Patient's Home                               |   | <input type="checkbox"/> Long Term Care         |               |
| <input type="checkbox"/> Physician's Office  |  | <input type="checkbox"/> Home Care Agency                             |   | <input type="checkbox"/> Other (explain): _____ |               |
| <input type="checkbox"/> Ambulatory Infusion Center  |  | <input type="checkbox"/> Outpatient Hospital Care                     |   | _____   |               |

# PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

|               |      |
|---------------|------|
| Patient Name: | ID#: |
|---------------|------|

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

| 1. Has the patient tried any other medications for this condition? | YES (if yes, complete below)                  | NO   |
|--|---|--|
| <b>Medication/Therapy</b><br>(Specify Drug Name and Dosage)        | <b>Duration of Therapy</b><br>(Specify Dates) | <b>Response/Reason for Failure/Allergy</b> |

| 2. List Diagnoses: | ICD-9/ICD-10: |
|--------------------|---------------|
|                    |               |

**3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.**

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

Attachments

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**Plan Use Only:** Date of Decision: \_\_\_\_\_

Approved  Denied Comments/Information Requested: \_\_\_\_\_