



fchp pharmacy prior authorization form

Fax completed form to 1-508-791-5101. For urgent situations, please call 1-866-275-3247, and select option 5. Services are subject to coverage, benefit, network and contract policies and exclusions.

Patient information

Last name: _____

First name: _____ MI: _____

DOB: _____

FCHP ID #: _____

Physician information

Physician name: _____

Specialty: _____

Phone: _____

Fax: _____

Signature: _____

Date: _____

Medication requested (one medication per form)

- New request for FCHP
- Renewal for FCHP

Name and strength of medication: _____

Directions for use: _____

Diagnosis: ICD-9 code (required): _____ Description (required): _____

Expected duration of therapy: _____

Medications or treatments previously used: _____

Reason why patient cannot use FCHP-preferred medications (formulary available at www.fchp.org):

Notes or relevant lab values: _____

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

Will medication be administered to the patient in the office/clinic? Yes No

If yes, complete the following:

▪ JCode: _____ NDC: _____

- Product will be obtained from:
 - FCHP-preferred vendor
 - MD stock
 - Other _____

(If not specified, FCHP-preferred vendor will be used. FCHP-preferred vendor information will be provided upon approval.)

Fallon Senior Plan 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. FCHP 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: _____

FCHP form #: _____

FCHP date received: _____