



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 #: _____

Medicare member? Yes No

Physician information

Physician name: _____

Specialty: _____

Phone: _____

Fax: _____

Signature: _____

Date: _____ NPI: _____

Medication requested (one medication per form)

New request for FCHP Renewal for FCHP

Name and strength of medication: _____

Directions/frequency of use: _____

Diagnosis ICD-9 code (required): _____

Diagnosis description (required): _____

Expected duration of therapy: _____

Medications or treatments previously used: _____

Reason why patient cannot use FCHP-preferred medications (formulary available at fchp.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: FCHP-preferred vendor MD stock Above rendering provider
(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: _____



FCHP Pharmacy Prior Authorization Form (page 2) Amitiza (lubiprostone) Clinical Information Worksheet

Please fax the completed FCHP pharmacy prior authorization form (page 1) and clinical information worksheet (page 2) to **1-508-791-5101**.

Member _____ DOB _____ FCHP ID# _____

- Please forward clinical notes from the patient's medical records documenting previously tried medication, reason for discontinuation of previously tried medication, and documentation of diagnosis (including any applicable labs and /or tests). This is required information.
- Please complete the clinical information requested below as completely as possible. Some questions may not pertain to some situations.
 - Has this patient had a GI consult? Yes No
If yes, please include provider name and date of consult: _____
 - Has the patient tried an increase in dietary fiber? Yes No
 - Has the patient tried at least one saline laxative, such as milk of magnesia, magnesium citrate, or Fleet phospho-soda? Yes No
 - Has the patient tried at least one stimulant laxative, such as sennosides (Ex-Lax, Senokot), bisacodyl (Dulcolax) or cascara sagrada? Yes No
 - Has the patient tried at least one other laxatives such as lactulose or polyethylene glycol (Miralax)? Yes No
 - For irritable bowel syndrome:
 - Has the patient had abdominal pain or discomfort occurring over at least 6 months with two or more of the following? Yes No
 - Check all that apply:
 - Relieved with defecation
 - Onset associated with a change in stool frequency
 - Onset associated with a change in stool form
 - For chronic idiopathic constipation:
 - How many spontaneous bowel movements per week does this patient have? _____
 - Has the patient had any of the following symptoms for at least 6 months? Check all that apply:
 - Very hard stools for at least a quarter of all bowel movements
 - Sensation of incomplete evacuation following at least a quarter of all bowel movements
 - Straining with defecation at least a quarter of the time
 - Other information: _____
