



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) Ampyra (dalfampridine) 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, including any applicable labs and/or tests, documenting the indicated diagnosis, patient condition, test scores, and lab values. This PA request will be denied without this documentation.**
- Please complete the clinical information requested below.
 - Is the patient currently on disease-modifying therapy for MS? Yes No
If yes, please provide medication name(s) _____
 - Does the patient have a walking impairment? Yes No
 - What is the time that it takes the patient to complete the 25 foot walk? _____
What is the date this test was completed? _____
 - What is the patient's EDSS score? _____
 - Does the patient have a history of seizures? Yes No
 - What is the patient's:
 - creatinine clearance? _____ml/min Date:_____
 - weight: _____ lbs or weight:_____kg Date:_____
 - serum creatinine:_____mg/dl Date:_____
 - BUN _____ Date:_____
 - Other information: _____
