



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) Aranesp, Epogen Clinical Information Worksheet

Please fax the completed FCHP pharmacy prior authorization form (page 1) and clinical information worksheet (pages 2 and 3) to **1-508-791-5101**.

FCHP preferred alternate:

Procrit* (separate PA required)

** For Procrit, please submit the Procrit PA form and worksheet. Otherwise, please complete the information requested below.*

Member _____ DOB _____ FCHP ID# _____

- Please forward clinical notes from the patient's medical records documenting diagnosis and 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 the patient tried and was intolerant of Procrit? Yes No
If yes, please forward notes from the patient's medical records documenting intolerance.
If no, please explain why Procrit could not be used: _____

- What is the cause of the patient's anemia? _____
- Does the patient have chronic renal failure? Yes No
 - Is the patient on dialysis? Yes No
- Does the patient have chemotherapy-induced anemia? Yes No
 - Has the provider enrolled in the ESA APPRISE Oncology program? Yes No
 - Has the patient signed the ESA APPRISE Oncology Patient and Healthcare Professional (HCP) Acknowledgement Form to document that the healthcare provider discussed the risks of erythropoietin with the patient? Yes No
 - Is the anticipated outcome of chemotherapy cure or not cure? Please choose one.
 - Is the patient currently receiving chemotherapy or within 8 weeks of the final chemotherapy dose? Yes No
- Will injections be given in office/clinic? Yes No

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FCHP Pharmacy Prior Authorization Form (page 3) Aranesp, Epogen Clinical Information Worksheet

Please fax the completed FCHP pharmacy prior authorization form (page 1) and clinical information worksheet (pages 2 and 3) to **1-508-791-5101**.

Member _____ DOB _____ FCHP ID# _____

- What is the patient's current hemoglobin (HGB)? _____ Date: _____
- What is the patient's current hematocrit (HCT)? _____ Date: _____
- Has the patient already begun erythropoietin treatment? Yes No

If yes, when was erythropoietin started and what were HGB and HCT levels prior to erythropoietin? (Please include dates of H&H levels.): _____

- At what HGB or HCT (please specify which) will doses be given? _____
- At what HGB or HCT (please specify which) will doses be withheld? _____
- For renewal, please include H&H levels and dates since the previous PA:

- Other information: _____
