



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) Boniva (ibandronate) 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.

FCHP preferred formulary alternates:

- alendronate
- Actonel

- Actonel 75 mg (2 tablets/month)
- Actonel 150 mg (1 tablet/month)

*If a formulary alternate is acceptable, please do **not** complete this PA form. Please forward a new prescription for the formulary alternate to the patient's pharmacy. Otherwise, please complete the information requested below.*

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.
 - Has the patient tried and failed or was intolerant to Fosamax? Yes No
 - Has the patient tried and failed or was intolerant to Actonel daily or weekly dosing? Yes No
 - Actonel is available in a once-monthly dose (150 mg tablet, once monthly). No PA is required for Actonel once monthly. Has the patient tried and failed Actonel once monthly? Yes No
 - Is there any reason why Fosamax or Actonel could not be used? (Please explain):

- Other information: _____
