



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) Botox, Myobloc (botulinum) 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.

- For migraines:

- How many migraines does the patient have per month? _____
- How many of these migraines are debilitating? _____
- Has the patient tried and failed or was intolerant to an NSAID or ASA/APAP with caffeine and butalbital? Yes No
- What triptans have been tried and failed? _____
- What prophylactic therapies have been tried and failed? _____
- Is there any reason why one of these medications could not be used? (Please explain): _____

- For severe primary axillary hyperhidrosis (SPAH):

- What is the patient’s HDSS score? _____
- Has the patient tried and failed topical prescription antiperspirants? Yes No
- Is there any reason why topical prescription antiperspirants could not be used? (Please explain): _____

- For achalasia:

- Has the patient tried and failed conventional therapy (nitrates or calcium channel blockers)? Yes No
- Is there any reason why conventional therapy could not be used? (Please explain): _____
- Has the patient failed a prior surgical myotomy or pneumatic dilation? Yes No
- Has the patient had a previous dilation-induced perforation? Yes No
- Is the patient at high risk of complications of dilation or myotomy? Yes No

- Other information: _____
