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)
Daytrana (methylphenidate) 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:

Methylphenidate, Ritalin SR, LA
Mixed Amphetamine Salts, Adderall XR
Concerta
Metadate ER, CD
Methylin ER

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.
  - Does the patient have clinically documented ADD or ADHD? ☐ Yes ☐ No
  - Has the patient failed long acting methylphenidate? ☐ Yes ☐ No
  - Has the patient failed long acting Adderall? ☐ Yes ☐ No
  - Does the patient have an inability to take oral formulations? ☐ Yes ☐ No
    If yes, please explain ____
  - Has the patient tried any of the above formulary medications? ☐ Yes ☐ No
    If yes, please check those that have been tried. If not listed, please indicate what medications have been used: ____
  - Is there any reason why one of the formulary medications could not be used? (Please explain) ____

    ____
  - Other information: ____

    ____