



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)
Follistim AQ (mid-cycle increase) 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, supporting the indicated diagnosis and medication usage that **clearly indicates why there is a need for larger amounts/longer length of therapy**. This is required information.
 - Please complete the clinical information requested below as completely as possible.
 - Along with the clear indication of why there is a need for larger amounts/longer length of therapy, please provide the following data for the **current** cycle:
 - Number of follicles achieved to date: _____
 - Follicle sizes achieved to date: _____
 - Estradiol level achieved to date: _____
 - Please provide the dates and doses of Follistim AQ the patient has already received this cycle: _____
 - What is the estimated number of **additional** days Follistim AQ will be required to complete cycle? _____
 - What daily dose of Follistim AQ is currently required? _____
 - Other information: _____
-
- Note: If approved, quantity approved will be on an as-needed basis only.