



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 (initial fill) 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 supports the requested quantities and length of therapy**. This is required information.
- Please complete the clinical information requested below as completely as possible.
- Has the patient tried and was intolerant to Gonal-F? Yes No
(If yes, please forward clinical notes from the patient's medical records documenting Gonal-F usage and intolerance.)
- Based on average dosing:
Limit for IUI is 1800 IU for a 10 day cycle
Limit for IVF is 2700 IU for a 10 day cycle
- What are the total units and days supply required? Units: _____ Days: _____
- Has the patient had a poor ovarian response in previous cycles? Yes No
 - In addition to above documentation, please provide info on **previous cycle**:
 - What were the number of follicles achieved? _____
 - Size of follicles: _____
 - What was the estradiol level achieved? _____
 - What was the total follitropin dose required? _____
 - What was the total length of follitropin therapy in days? _____
- Is the patient likely to have a poor response based on pre-cycle assessment of ovarian reserve? Yes No
 - If yes, in addition to above documentation, please provide **pre-cycle assessment** of:
 - FSH level: _____
 - Estradiol level: _____
- Is there any other reason why the patient would require larger than normal doses? Please explain: _____
- Other information: _____