



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) Gonal-F (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.
 - 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 Gonal-F dose required? _____
 - What was the total length of Gonal-F 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: _____
