



# 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) Letairis (ambrisentan) 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, documentation of diagnosis (including any applicable labs and /or tests) and documentation of delay in clinical worsening (if a renewal request). This is required information.
- Please complete the clinical information requested below as completely as possible.
  - What is the patient’s World Health Organization (WHO) classification **group**?: \_\_\_\_\_
  - Did the patient have a positive vasoreactivity test?     Yes                     No
    - If yes, has the patient tried and failed a calcium channel blocker?  Yes             No
    - Is there any reason why a calcium channel blocker could not be used? Please explain:  
\_\_\_\_\_
  - What is the patient’s current WHO **functional class**?: \_\_\_\_\_      Date: \_\_\_\_\_
  - What is the patient’s current 6-minute walk distance? \_\_\_\_\_      Date: \_\_\_\_\_
  - What is the patient’s current mean pulmonary artery pressure? \_\_\_\_\_      Date: \_\_\_\_\_
  - What are the patient’s current aminotransferase and bilirubin levels?
    - ALT \_\_\_\_\_      Date \_\_\_\_\_
    - AST \_\_\_\_\_      Date \_\_\_\_\_
    - Bilirubin \_\_\_\_\_      Date \_\_\_\_\_
  - For women of childbearing age:
    - What was the patient’s pregnancy test result? \_\_\_\_\_      Date: \_\_\_\_\_
    - Is patient using 2 reliable methods of contraception?     Yes             No
    - Has patient had tubal sterilization or an IUD inserted?  Yes             No
  - Other information: \_\_\_\_\_  
\_\_\_\_\_