



# 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) Nuvigil (armodafinil) 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

dextroamphetamine

*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. Some questions may not pertain to some situations.
- Does the patient have any of the following conditions? Please check all that apply:
  - Narcolepsy
    - 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): \_\_\_\_\_  
\_\_\_\_\_
  - Obstructive sleep apnea
    - Is the patient compliant with continuous positive airway pressure (CPAP) for at least 4 hours per night for at least 2 months?  Yes  No
  - Shift work sleep disorder
    - What is the patient's exact hourly work schedule, days, rotations, and frequency of rotations? \_\_\_\_\_