



# 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) Procrit (epoetin) 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 diagnosis and 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.
  - What is the cause of the patient's anemia? \_\_\_\_\_
  - Does the patient have chronic renal failure?  Yes  No
    - Is the patient on dialysis?  Yes  No
  - Does the patient have chemotherapy-induced anemia?  Yes  No
    - Has the provider enrolled in the ESA APPRISE Oncology program?  Yes  No
    - Has the patient signed the ESA APPRISE Oncology Patient and Healthcare Professional (HCP) Acknowledgement Form to document that the healthcare provider discussed the risks of Epoetin with the patient?  Yes  No
    - Is the anticipated outcome of chemotherapy **cure** or **not cure**? Please choose one.
    - Is the patient currently receiving chemotherapy or within 8 weeks of the final chemotherapy dose?  Yes  No
  - Will injections be given in office/clinic?  Yes  No
  - What is the patient's current hemoglobin? \_\_\_\_\_ Date: \_\_\_\_\_
  - What is the patient's current hematocrit? \_\_\_\_\_ Date: \_\_\_\_\_
  - Has the patient already begun Procrit treatment?  Yes  No

If yes, when was Procrit started and what were hemoglobin and hematocrit levels prior to Procrit? (Please include dates of H&H levels.): \_\_\_\_\_

- At what hemoglobin or hematocrit (please specify which) will doses be given? \_\_\_\_\_
- At what hemoglobin or hematocrit (please specify which) will doses be withheld? \_\_\_\_\_
- For renewal, please include H&H levels and dates since the previous PA:  
\_\_\_\_\_