



# 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) Provigil (modafinil) 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:

Narcolepsy:

methylphenidate

dextroamphetamine

Multiple sclerosis:

amantadine

*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 and failed or was intolerant to methylphenidate or dextroamphetamine?  Yes  No
    - If no, is there any reason why one of these 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
  - Fatigue due to multiple sclerosis
    - Have other causes of fatigue been ruled out?  Yes  No
    - Has the patient tried and failed or was intolerant to amantadine?  Yes  No
    - If no, is there any reason why amantadine could not be used? (Please explain):  
\_\_\_\_\_
  - Shift work sleep disorder
    - What is the patient's exact hourly work schedule, days, rotations, and frequency of rotations? \_\_\_\_\_