



# 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) Xolair (omalizumab) Clinical Information Worksheet

Please fax the completed FCHP pharmacy prior authorization form (page 1) and clinical information worksheet (pages 2 and 3) 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, patient’s current condition 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.
  - Has the patient had clinically documented severe persistent asthma for greater than 1 year?
    - Yes       No
    - Check all that apply:
      - Reversible airflow obstruction
      - Bronchial hyperactivity (challenged)
      - FEV1 >40% to <80% of predicted normal, pre-inhaled steroids
  - Have co-morbidities been ruled out that can cause asthma exacerbations?  Yes       No
    - Check all that apply:
      - Sinusitis
      - GERD
      - Allergic rhinitis
      - OTC and Rx medications
  - Have non-asthma diagnoses been ruled out?  Yes       No
    - Check all that apply:
      - Hyperventilation
      - Laryngeal dysfunction
      - Panic disorder
  - What was the patient’s IgE level (Please forward lab results)?
    - IgE: \_\_\_\_\_ IU/ml      Date: \_\_\_\_\_
  - Did the patient test positive to one or more perennial aeroallergen by a skin test or blood test (RAST)?  Yes       No
    - If yes, please list positive aeroallergens (and forward lab results):
    - \_\_\_\_\_

Continued on next page



# FCHP Pharmacy Prior Authorization Form (page 3) Xolair (omalizumab) Clinical Information Worksheet

Please fax the completed FCHP pharmacy prior authorization form (page 1) and clinical information worksheet (pages 2 and 3) to **1-508-791-5101**.

Member \_\_\_\_\_ DOB \_\_\_\_\_ FCHP ID# \_\_\_\_\_

- o Has the patient tried and failed or was intolerant to the following medication classes? Please answer yes or no to all and include duration of therapy:

Medication Class	Failed or intolerant?		Length of therapy
systemic corticosteroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
inhaled corticosteroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
short-acting B2 agonists	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
long-acting B2 agonists	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
leukotriene modifier	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
theophylline	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
combination therapy (see below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

List meds used in combination: \_\_\_\_\_

- o Was the patient compliant on previous therapies?  Yes  No
- o Has the patient been educated and evaluated in the proper self-administration techniques of administering asthma medications?  Yes  No
- o Was the patient's asthma **inadequately** controlled using oral inhaled corticosteroids at maximum doses for at least 3 months? (Inadequate control on inhaled corticosteroids is demonstrated by hospitalization for asthma and requirement for systemic (oral or parenteral) corticosteroids to control exacerbations of asthma.)  Yes  No
- o What is the patient's current asthma therapy? \_\_\_\_\_
- o Is the patient compliant with the current asthma therapy?  Yes  No
- o What is the patient's current Asthma Control Test result? \_\_\_\_\_ Date: \_\_\_\_\_
- o Is the patient a current smoker?  Yes  No
  - If yes, is the patient currently enrolled in a smoking cessation program?  Yes  No (Expectation is that the patient will stop smoking.)
- o What is the patient's current body weight?: \_\_\_\_\_ kg or lbs
- o Has the patient had a consult by a pulmonary or allergy specialist?  Yes  No
  - If yes, specialist's name and date of consult: \_\_\_\_\_
- o What are the patient's PFT's? Please include a copy of recent tests.
 

FVC: _____	Date: _____
TLC: _____	Date: _____
RV: _____	Date: _____
FEV1: _____	Date: _____
PEF: _____	Date: _____