



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)
Beconase AQ, Flonase, Nasacort AQ, Omnaris, Rhinocort
AQ, Veramyst 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:

Generic fluticasone nasal spray

Generic flunisolide nasal spray

*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.
 - Has he patient tried, for at least 2 weeks and failed, or was intolerant to generic flunisolide?
 Yes No
 - Has he patient tried, for at least 2 weeks and failed, or was intolerant to generic fluticasone? Yes No
 - Is there any reason why a formulary medication could not be used? (Please explain):

▪ Other information: _____
