Prior authorization form for medical benefit drugs

This form is for Medicare and Medicaid member PA requests only. It is not to be used for Commercial member PA requests. Please use this form for prior authorizations that pertain to physician-administered drugs only (including home infusion). **Fax completed form to 1-508-791-5101**. Services are subject to coverage, benefit, network and contract policies and exclusions.

Patient information

Last name: _____ First name: _____ MI: _____

DOB: _____ Fallon Health ID #: _____

Physician information

Physician name: _____ Specialty: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____ NPI: _____

Medication requested (one medication per form)

☐ New request for Fallon ☐ Renewal for Fallon

Name and strength of medication: _____

Directions/frequency of use: _____

Diagnosis ICD-10 code *(required)*: _____

Diagnosis description *(required)*: _____

Expected duration of therapy: _____

Medications or treatments previously used: _____

Reason why patient cannot use Fallon -preferred medications *(formulary available at fallonhealth.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:

☐ Fallon-preferred vendor ☐ MD stock ☐ Above rendering provider *(If not specified, Fallon-preferred vendor will be used. Fallon-preferred vendor information will be provided upon approval.)*

Member-requested 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. Fallon 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: _____