



# PRIOR AUTHORIZATION REQUEST

## Global Non-Formulary Criteria

PATIENT: Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
D.O.B. \_\_\_\_\_  
Member ID: \_\_\_\_\_

Prescriber: Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
NPI \_\_\_\_\_

**Medication Requested:** \_\_\_\_\_ **Qty Requested:** \_\_\_\_\_

mm\_name1 Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

### SECTION A Please answer the following questions

1.  Yes  No Is the requested medication prescribed for an oncology-related condition (such as cancer, leukemia, myelodysplastic syndrome or supportive medications such as anti-emetics or colony-stimulating factors)?  
**If the answer to this question is YES, then no further questions required. For oncology-related diagnosis, please obtain authorization through Eviti Oncology Service at 1-888-678-0990, or www.Eviti.com**
2.  Yes  No Is the requested medication a mental health medication?  
**If the answer to this question is YES, then no further questions required. Medications for HIV and mental health conditions are covered by the state. The pharmacy should process the prescription through the mental health pharmacy vendor, Xerox/ACS, bin #610084.**
3.  Yes  No Is this a RENEWAL request for a previous authorization of this medication?
4.  Yes  No If **Yes** to the previous question, is the patient responding to therapy with the requested medication?
5. Please document the diagnosis or indication for the requested medication and the dose based on the patient's age and indication (**please document below**):

6.  Yes  No Does the patient have an appropriate diagnosis or indication for the requested medication?
7.  Yes  No Is the dose of the requested medication appropriate, based on the patient's age and indication?
8.  Yes  No Did the patient experience intolerance or adverse side effect to the generic formulations made by TWO different manufacturers?
9.  Yes  No Did the patient experience a treatment failure with a trial of generic formulations made by TWO different manufacturers?

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If you have any  
questions, call:  
800-753-2851



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10. [ ]Yes [ ]No Has a MedWatch Form 3500 been completed and submitted with this request? NOTE: The MedWatch form can be obtained from: http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

11. Please provide the names of ALL medications that are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy. Please Note: The type of contraindication must be included for each medication (such as drug allergy or serious drug interaction).

Horizontal lines for providing medication names and contraindications for question 11.

12. Please provide the names of ALL medications that the patient has tried. Please Note: For each medication, include whether it is current or past treatment, and the DATES and DURATION of therapy with each of these agents.

Horizontal lines for providing medication names, dates, and durations for question 12.

Please document the diagnoses, symptoms, and/or any other information important to this review:

Horizontal lines for documenting diagnoses, symptoms, and other information.

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851