Priority health drug prior authorization form

Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**

PriorityHealth

Fax Form To: 616.942.0024

Implantable Cardioverter Defibrillators (ICD) & Biventricular Pacemakers

Member

Last name: _____ First name: _____

ID #: _____ DOB: _____

Primary care physician: _____ PCP phone: _____ PCP fax: _____

Requested By:

Provider name: _____ Phone: _____ Fax: _____

Address: _____ Contact name: _____ Date of request: _____

Directed To:

Provider name: _____ Facility: _____

Address: _____ Address: _____

Provider phone: _____ Fax: _____ Facility phone: _____ Fax: _____

Contact name: _____ Contact name: _____ Date of service: _____

Clinical Information:

ICD check the condition(s) that apply: ☐ Initial Placement ☐ Replacement - Date of Original Placement: _____

If replacement, reason for replacement: _____

Manufacturer name: _____ Model #: _____

Implantable Cardioverter Defibrillators (ICDs) are covered consistent with the recommendations for Class I and Class IIa indications found in the ACC/AHA/HRS Guidelines for Device-Based Therapy.

CARDIOVERTER DEFIBRILLATORS – ADULT CRITERIA

For Implantable Cardioverter Defibrillators **all** of the following are required:

1. ☐ Patient must be on optimal medical therapy.
2. ☐ Patient must have a reasonable expectation of survival with good functional status for more than 1 year, **and**
3. ☐ Patient must meet **one** of the following criteria for adults:

Please check the indication that applies to this request for prior authorization:

☐ Survival of cardiac arrest due to ventricular fibrillation (VF) or hemodynamically unstable sustained ventricular tachycardia (VT) after evaluation to define the cause of the event and to exclude any completely reversible causes. (Class I)
Date of event: _____

☐ *Left ventricular dysfunction with prior MI (Ischemic Cardiomyopathy) and one of the following:
- a. LVEF less than 35% due to prior MI who are at least 40 days post myocardial infarction and who are in NYHA functional Class II or III. (Class I)
- b. LVEF less than 30%, at least 40 days post myocardial infarction, and are in NYHA functional Class I. (Class I)
- c. nonsustained VT due to prior MI, LVEF less than 40%, and inducible VF or sustained VT at electrophysiological study. (Class I

EF _____ **Date of MI** _____

☐ *Nonischemic dilated cardiomyopathy with an LVEF less than or equal to 35% and who are in NYHA functional Class II or III.(Class I) **EF** _____

***Indications must also meet the following criteria:**

1. Ejection fractions must be measured by angiography, radionuclide scanning, echocardiography, or MRI.
2. MIs must be documented and defined according to the consensus document of the Joint European Society of Cardiology/American College of Cardiology committee for the Redefinition of Myocardial Infarction." **(Please see Medical Policy 891410 Cardioverter Defibrillators for additional criteria)**

☐ Syncope of undetermined origin and one of the following:
- a. clinically relevant, hemodynamically significant sustained VT or ventricular fibrillation induced at electrophysiological study. (Class I)
- b. significant LV dysfunction, and nonischemic dilated cardiomyopathy. (Class IIa)

☐ Ventricular Tachycardia and one of the following:
- a. structural heart disease and spontaneous sustained VT, whether hemodynamically stable or unstable. (Class I)
- b. sustained VT and normal or near normal ventricular function. (Class IIa)

☐ Familial or inherited conditions **(Please refer to Medical Policy 891410 Cardioverter Defibrillators for specific criteria)**

☐ Non hospitalized patients awaiting heart transplantation (Class IIa)

Continue to Page 2

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit,
550 High St., Suite 1000, Jackson, MS 39201

☐ Medicaid Fee for Service/Change Healthcare
Fax to: 1-877-537-0720 Ph: 1-877-537-0722
https://medicaid.maximus.com/providers/pharmacy/pharmacy-prior-authorizations/

☐ Magnolia Health/Envolve Pharmacy Solutions
Fax to: 1-866-399-0929 Ph: 1-866-399-0928
https://www.magnoliahealthplan.com/providers/pharmacy.html

☐ UnitedHealthcare/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-programs.html

BENEFICIARY INFORMATION	
Beneficiary ID: ___ ___ ___ - ___ ___ ___ - ___ ___ ___	DOB: ___ ___ / ___ ___ / ___ ___ ___ ___
Beneficiary Full Name:	
PRESCRIBER INFORMATION	
Prescriber's NPI:	
Prescriber's Full Name:	Phone:
Prescriber's Address:	FAX:
PHARMACY INFORMATION	
Pharmacy NPI:	
Pharmacy Name:	
Pharmacy Phone:	Pharmacy FAX:

CLINICAL INFORMATION

Requested PA Start Date: _____ Requested PA End Date: _____

Drug/Product Requested: _____ Strength: _____ Quantity: _____

Days Supply: _____ RX Refills: _____ Diagnosis or ICD-10 Code(s): _____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification

PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW

Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

Signature required: _____ Date: _____

Printed Name of Prescribing Provider: _____

FAX THIS PAGE

PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8026

This form applies to: ☒ **Commercial** ☐ **Medicaid** ☐ **MIChild**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. The standard review time averaged between 1 and 5 business days.

Aveed® (testosterone undecanoate)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: ☐ Aveed 750 mg/3mL

Date of last dose (if applicable): _____

Dosing frequency: _____

Start date (or date of next dose): _____

Place of administration:
- ☐ Self-administered
- ☐ Provider's office
- ☐ Outpatient infusion center
- ☐ Home infusion

Center name: _____

Agency name: _____

Billing:
- ☐ Physician buy and bill
- ☐ Preferred specialty vendor
- ☐ Other: _____

ICD code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Patient is male
2. Patient is hypogonadal, as evidenced by both of the following:
   - Clinical signs and symptoms consistent with androgen deficiency (requests for coverage to treat decreased libido with no other symptoms is not a covered benefit), and
   - Subnormal serum total testosterone concentration (lab results must be included or faxed with request)
     - Subnormal is defined as less than 300 ng/dL, on more than one occasion in the previous 12 months, for men less than 80 years old
     - Subnormal is defined as less than 350 ng/dL, on more than one occasion in the previous 12 months, for men age 80 years and older
3. Documentation of prior use with injectable testosterone (e.g. testosterone enanthate 150 to 200 mg every two weeks) for a minimum of two months. If patient experiences fluctuations in energy, mood, or libido, after two months or more, the dosage can be changed (e.g. testosterone enanthate 100 mg once a week).
4. After a trial with injectable testosterone, must then first try Androgel or Axiron
5. Men age 50 and older (or 40 and older for men with a family history or are African-American) should be screened for prostate cancer before starting therapy and routinely while on therapy

All fields must be complete and legible for review. Your office will receive a response via fax.

New 05/2014
Last reviewed 05/2015

Manulife Financial
For your future®

Group Benefits
Drug Prior Authorization

Please select the drug name:

The purpose of this form is to obtain the medical information required to assess your request for a drug on the Prior Authorization list under your drug plan benefit coverage. Please ensure this form is filled in completely or it will delay the processing of your request. Completion of this form is not a guarantee of approval. If you have already purchased the drug, please attach all original receipts along with an Extended Health Care Claim form. All costs incurred to complete this form are the plan member's responsibility.

If you are registered for the Plan Member Secure Site and have provided an email address, you will receive an email notification when the prior authorization decision is available on your claims statement. If you are not registered on the Plan Member Secure Site, you will be notified of the prior authorization decision by mail.

1 Plan member and patient information

To be completed by plan member

Plan contract number	**Plan member certificate number**	Plan sponsor
Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)	Gender ◯ Male ◯ Female
Plan member address (number, street and apt.)	City or town / Province	Postal code
Phone number	Email address (optional)	
Patient name (first, middle initial, last)	Patient date of birth (dd/mmm/yyyy)	Relationship to plan member

2 Provincial Plans

To be completed by plan member

Most provinces offer some form of drug coverage to their residents. Your Manulife drug plan supplements the coverage provided by provincial plans. It is important that you or your doctor (if required) apply to the applicable provincial program to ensure there are no delays in your drug reimbursement.

Login to the **Manulife Provincial Drug Plans Resource Centre** on our Plan Member Secure Site at www.manulife.ca/groupbenefits to confirm if the drug you have been prescribed may be eligible for coverage under a provincial plan. If the drug you have been prescribed is listed under a provincial program, you will need to apply to the program before consideration can be given under your Manulife drug plan.

Have you applied to the provincial program for coverage? ◯ Yes ◯ No

Have you been approved for coverage by the provincial program for this drug? ◯ Yes ◯ No

Drug strength and dosage

Where will the treatment be administered?

◯ Home ◯ MD Office ◯ Private Clinic ◯ Hospital/In-patient ◯ Hospital/Out-patient

PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.374.4411 toll free, or 616.942.8206

This form applies to: ☒ **Medicare Part B** ☐ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Botulinum toxin (Botox, Dysport, Myobloc, and Xeomin)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ Botox 100 unit vial ☐ Myobloc 2,500 unit vial
☐ Botox 200 unit vial ☐ Myobloc 5,000 unit vial
☐ Dysport 300 unit vial ☐ Myobloc 10,000 unit vial
☐ Dysport 500 unit vial
☐ Xeomin 50 unit vial
☐ Xeomin 100 unit vial

Start date (or date of last dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Place of administration: ☐ Provider's office
☐ Outpatient infusion center
☐ Home infusion

Center name: _____
Agency name: _____

Billing: ☐ Physician buy and bill
☐ Preferred specialty vendor
☐ Other: _____

ICD code(s): _____

Priority Health Medicare plans

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

WPS Medicare LCD L28555

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2014
Last reviewed 01/2016

3,968 Downloads (No Ratings Yet)Loading... A PriorityHealth Pharmacy Prior Authorization Form is a way for plan members to receive coverage for non-covered medication. This form should be completed by the prescriber or healthcare professional in order to provide sufficient justification for the necessity of the non-formulary to treat their patient's current diagnosis. The below form can be used for commercial, medicaid and MIChild insurance. Once completed, fax to 1 (877) 974-4411 or 1 (616) 942-8206. Step 1 – Download the form in Adobe PDF to begin. Step 2 – Once the form is open on your computer, check whether or not the request is urgent or non-urgent. Step 3 – The first window requests the member's full name, ID #, date of birth, gender, and physician's name. Next supply the following info pertaining to the provider: Provider name Phone number Fax number Address NPI Contact name Once the form has been printed off, the date of signing and the signature can be supplied. Step 4 – Here the product information can be supplied. This will require all of the below data. Medication request Start date Strength of medication Date of last dose (if applicable) Dosing frequency Anticipated length of therapy Step 5 – Here is where the medical reasoning for the non-covered medication can be supplied. List the patient's medical condition and explain the medical reasoning in paragraph format. A full list of previously attempted drugs to treat the conditions should be supplied and below that, any additional information that may support the argument. Step 6 – Print off the form, provide the provider signature as mentioned in step 3, then fax the completed form to the numbers found at the top of the page. Here are some forms you may need to help you manage your health coverage. Authorization for Release of Health Information – Standing: This form lets you choose someone you trust to have access to your health records. You can also decide how much of your personal health information you want that person to know. Don't worry, if you don't fill out this form, Priority Partners will continue to keep your health information protected and private. Authorization for Release of Health Information – Specific Request: Like the "standing" version of this form, you can choose someone you trust to have "one-time" access to a specific part of your personal health information. Don't worry, if you don't fill out this form, Priority Partners will continue to keep your health information protected and private. Pharmacy Compound Drug Prior Authorization Form: If your doctor is not able to substitute an ingredient in a medication or prescribe a different drug to you, they will need to fill out this form to request prior authorization for a compound drug. Pharmacy Prescription Reimbursement Standard Claim Form: If you previously paid for prescriptions without using your Priority Partners insurance, you can fill out this form to start the reimbursement process. Note: Your request will be reviewed, and reimbursement is not guaranteed. Pharmacy Prescription Reimbursement Secondary Claim Form: This form should be used ONLY if you are submitting claims for secondary prescription coverage. Note: Your request will be reviewed, and reimbursement is not guaranteed. Pharmacy Prior Authorization Form: Drugs that are not listed in the formulary must be approved by your doctor before they can be filled at the pharmacy. Your doctor can request this drug by filling out a prior authorization request. Instructions on how to submit a request is on the provider site. Your prescribing doctor will need to tell us the medical reason why your Priority Partners plan should authorize coverage of your prescription drug. Representation of Responsibility for Minor Child: If you are over 18 years old, filling out this form will give you the right to represent and make health care information-related decisions about a minor child who is 17 years old or younger. The adult representative can only be the minor's parent, step-parent, legal guardian, or kinship caregiver. All documents are available in paper form without charge. To request a paper copy, please call Customer Service at 800-654-9728 (TTY for the hearing impaired: 888-232-0488). The Centers for Medicare and Medicaid Services (CMS) rules require that all Part C (Medicare Advantage) plans - NOT providers - give a specific written notice to members if a service or item isn't covered. The process for getting this written notice of non-coverage from Priority Health is called requesting a pre-service organization determination (PSOD). The PSOD process differs from the rule for fee-for-service Medicare ("Original Medicare") patients, which allows you, the provider, to give written notice. The Part C rule can be found in the Medicare Managed Care Manual, Section 160, Chapter 4, Benefits and Beneficiary Protections. It applies to all Part C Medicare Advantage plans. Whether or not the member requests a PSOD, the member can't be held financially responsible for a non-covered service unless there's a clear exclusion in the member's Evidence of Coverage (EOC) plan document, OR Priority Health issues a Notice of Denial of Medicare Coverage. When a PSOD is not needed When a service or device is specifically excluded from coverage by the member's Evidence of Coverage document, providers may tell the member that the service will not be covered and the member will be financially responsible for the service or device. No PSOD or form is needed. Document this conversation in the patient's record. See the list of EOC exclusions. To notify a patient who is already receiving care in a skilled nursing facility that they no longer need skilled nursing care and it will no longer be covered by their plan, skilled nursing facilities (SNFs) may issue the Notice of Medicare Non-coverage form to Medicare Advantage plan members. See details. Discuss non-coverage with the Medicare Advantage plan member When an item or service is not specifically excluded from Medicare coverage by the Medicare Advantage plan Evidence of Coverage (EOC) policy document (see a list of EOC exclusions), but you believe it won't be covered by the member's plan: 1. Advise the member: This is a Part C member right; that is, the member has the right to know if something is or isn't covered. CMS wants to be sure Part C plan members know whether they will incur any additional costs other than their plan cost share. 2. Offer to obtain a PSOD. Priority Health will review the member's medical information and CMS rules/regulations to determine coverage and notify both you and the member of our decision. 3. If the member refuses, document the refusal in the medical record. Explain to the member that he or she will have to pay 100% of the cost of any medical services that Medicare doesn't cover. Some health care services, treatment plans, prescription drugs and durable medical equipment require a formal approval from Priority Health in advance before your plan will pay for them. Sometimes called prior authorization, prior approval or precertification, preauthorization isn't a promise Priority Health will cover the cost. The preauthorization requirement doesn't usually apply in emergencies. False print Home Providers Prior Authorization "Prior Authorization" is a term used for select services (e.g., homecare services), items (e.g., Durable Medical Equipment purchases over $500) and prescriptions for some injectable or infusion drugs (e.g., Botox, Soliris, OxyContin) that must be pre-approved by Health Partners Plans. Prior Authorizations are sometimes referred to as "preauthorizations" or "precertifications" – they mean the same thing. Note: Health Partners Plans requires prior authorizations for select services performed in an outpatient setting, including those performed in the office, short procedure units, ambulatory surgery centers, clinics, and hospital outpatient departments. Prior Authorization Guidelines Our Prior Authorization Guidelines provide an up-to-date list of all services requiring prior authorization. In additon, our medical drugs list is updated frequently. Health Partners (Medicaid) and KidzPartners (CHIP) Health Partners Medicare Medical Oncology Drugs Medical Oncology Drugs - eviCore (Excel; updated 7/12/22) Pharmacy Prior Authorization Request Forms If you want to request a non-formulary drug or a formulary drug that requires prior authorization, please use the appropriate forms as indicated below. Health Partners (Medicaid), KidzPartners (CHIP) Health Partners Medicare Drug-Specific Prior Authorization Forms — Use the appropriate request form to help ensure that all necessary information is provided for the requested drug Fax all completed Health Partners Medicare prior authorization request forms to 1-866-371-3239.

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