nh healthy families

Phone: (877) 250-5227
Fax: (833) 645-2738

Send To: ❍ Pharmacy Services
Date: _____
Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Prior Authorization Form
Specialty Drug

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Patient Soc. Sec #: _____ Allergies: _____
Date of Birth: ___/___/___ Sex: ❍ Male ❍Female Weight _____ ❍lbs ❍kg
Height: _____ BSA: _____ m² ❍See attached demographic sheet

Physician Name: _____
State Lic # _____ DEA # _____
NPI # _____ Specialty: _____
Practice Name/Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Physician's Ph: (_____) _____ - _____
Physician's Fax: (_____) _____ - _____
Nurse/Key Office Contact: _____

INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance: _____
City: _____ State: _____
Plan #: _____
Group #: _____
Phone: (_____) _____ - _____

Secondary Insurance: _____
City: _____ State: _____
Plan #: _____
Group #: _____
Phone: (_____) _____ - _____

Rx Card (PBM): _____
PBM BIN: _____
City: _____ State: _____
Group #: _____
Phone: (_____) _____ - _____

Cardholder First Name: _____
Last Name: _____
Employer: _____
ID #: _____
Group #: _____

DIAGNOSIS *(Required)*

What is the ICD 9 / ICD 10 code? _____

PATIENT EVALUATION

1. Is the member currently treated with this medication?
   - ❑ Yes; if yes, please continue
   - ❑ No; if no, please continue to question #4

2. How long has the patient been on treated with this medication: _____ ❑ years ❑ months

3. Has the patient had a positive outcome? ❑ Yes ❑ No

4. Please indicate previous treatments and outcomes?

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		
NOTE: confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria		

5. Please state Rationale for Request / Pertinent Clinical Information (Required for all prior authorizations)

****NOTE: We can NOT make a decision without a copy of pertinent lab results and/or the current clinical progress notes - Thank You****

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Physician's Signature: _____ ❍ DAW (Dispense as Written **Date** ____/____/____