PRIOR AUTHORIZATION for MEDICAL/CASE MANAGEMENT MEDICATION

For authorization, please complete this form, include patient chart notes to document clinical information and fax the information back to the PEHP Prior Authorization Department at (801) 245-7774 or mail to: PEHP Pharmacy Services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7555.

Section I: PATIENT INFORMATION

Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Date Requested:	Service Provider Name:	Service Provider NPI #:	Service Provider Tax ID #:

Provider Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*

☐ Authorization Extension ☐ Pre-Authorization ☐ Retro Authorization ☐ Urgent

Requested Dates of Service:

Place/Site of Service: *Please check.*

☐ Home/Home Health ☐ Infusion Center ☐ Inpatient ☐ Outpatient ☐ Office

Requested Source of Medication: *Please check.*

☐ Accredo ☐ Facility ☐ Home Health ☐ Physician

Facility/Home Health Agency Name:	Facility/Home Health Agency NPI #:	Facility/Home Health Agency Tax ID #:

A. Please list the name of the medication (s), dosage, route, frequency, and CPT/HCPCS code (s) that you are requesting:

Drug Name	CPT / HCPCS Code	Dose	Route of Administration	Frequency

B. Please list the primary / secondary diagnosis and the ICD-10:

Diagnosis Description	ICD-10
Primary Diagnosis:	
Secondary Diagnosis:	

**** If the use of the medication is for a non-FDA, NCCN or nationally recognized Compendia approved indication please provide clinical studies or articles that support the use of the medication in the patient's diagnosis.***

C. Please list any previous treatment to treat the diagnosis, date of treatment, and the reason for the discontinuation of therapy:

Treatment	Date (s) of Treatment	Reason for Discontinuation of Therapy

D. Please list any other medication that will be used in combination with the requested medication:

Drug Name	CPT / HCPCS Code	Dose	Route of Administration	Frequency

Additional Comments:

Physician's Signature:	Date: