

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 #:
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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: <i>Please check.</i>	Requested Dates of Service:	
<input type="checkbox"/> Authorization Extension <input type="checkbox"/> Pre-Authorization <input type="checkbox"/> Retro Authorization <input type="checkbox"/> Urgent		
Place/Site of Service: <i>Please check.</i>	Requested Source of Medication: <i>Please check.</i>	
<input type="checkbox"/> Home/Home Health <input type="checkbox"/> Infusion Center <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office	<input type="checkbox"/> Accredo <input type="checkbox"/> Facility <input type="checkbox"/> Home Health <input type="checkbox"/> 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:
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