MEDICAL/CASE MANAGEMENT MEDICATION
PRIOR AUTHORIZATION REQUEST FORM

For authorization, please complete this form, include patient chart notes to document clinical information and **fax the information back to the PEHP Clinical Services Department at (801) 320-0958** or mail to: PEHP Medical Case Management, 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. *You may also view a list of medications that require prior authorization through our pharmacy department as well as obtain a prior authorization form by going to* ***www.pehp.org***.

1. Date:	**2. Patient Name:**	**3. ID #:**
4. D.O.B:	**5. Physician:**	**6. Office Phone:**
7. Office Fax:	**8. Office Contact:**	**9. Sex:**

10. Authorization is requested from _____/_____/_____ to _____/_____/_____.

11. Please list the name of the medication(s), dosage, route, frequency and CPT or J code(s) that you are requesting:

Drug Name	CPT /J Code	Dose	Route of Administration	Frequency

12. Please list the diagnosis and the ICD-10 of the patient:
Diagnosis:

ICD-10 Code(s):

13. 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.

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

Treatment	Date of Treatment	Reason for Discontinuation of Therapy

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

Drug Name	CPT /J Code	Dose	Route of Administration	Frequency

16. Physician's Signature: ____

PEHP USE ONLY

Date of Review:	**Reviewer Name:**	**Approval** ☐ **Denial** ☐
Rationale:		
Date of Approval:	**Auth #:**	
	Notify Case Management: Date:	Nurse: