Pharmacy Medication

PRIOR AUTHORIZATION REQUEST FORM

For authorization, please answer each question, include patient chart notes to document clinical information, and fax this form 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 contact the PEHP Pharmacy Customer Service at (801) 366-7551.

If the medication you are requesting has a specific prior authorization form, the specific form will be sent to you and must be completed for further review of the authorization.

The last 6 months of chart notes or clinical documentation is required for review.

1. Date: Click or tap to enter a date.	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Sex:
10. Weight:	Authorization is requested from: / / to / /	

11. List the diagnosis and the ICD-10 of the patient below:

ICD-10:	Diagnosis:

12. List the name of the medication(s), strength, route, and the dosing/frequency being requested:

Drug Name	Strength	Route	Dosing/Frequency

13. Select the source of the medication: ☐ Accredo (pharmacy benefit) ☐ Approved Home Health ☐ Physician (Buy & Bill by J-code)

14. If using the medical benefit specify the CPT/J-codes being requested, where the medication will be obtained, and where it will be administered:

CPT/J-codes	Medication Obtained From	Place of Administration (include NPI)

15. Does the facility or provider doing the administration accept medication from Accredo? ☐ Yes ☐ No

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

17. List any previous treatment used for the diagnosis, date of treatment, and the reason for the discontinuation of therapy:

Treatment	Dates of Treatment	Reason for Discontinuation of Therapy

18. List any other medication that will be used in combination with the requested medication:

Drug Name	Strength	Route	Dosing/Frequency	CPT/J-codes

17. Physician's signature: