OUTPATIENT MEDICATION
PRIOR AUTHORIZATION REQUEST FORM

INSTRUCTIONS:

1. **Complete** the attached PA request form. **All fields must be completed**.
2. **Attach** any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.
3. **Submit** the completed form and supporting information to the Alliance Pharmacy Benefits Manager (PBM), PerformRx at **855.811.9329**.

NOTE: This form is **only** used for **drugs dispensed from a retail or specialty pharmacy**.
For Physician Administered Drugs (i.e., "buy and bill") and associated procedure codes, please use the Alameda Alliance for Health (Alliance) Medical Management Prior Authorization (PA) request form, found on the Alliance website: **www.alamedaalliance.org/providers/resources/forms**.

SUMMARY:
As of Tuesday, January 1, 2018, the Alliance will ONLY accept the Department of Managed Health Care (DMHC) mandated state-wide PA request form 61-211 *(revised 12/16)* for drugs dispensed from a pharmacy which can be found on the attached page and online at the Alliance website: **www.alamedaalliance.org/providers/pharmacy-drug-benefits**. This requirement is in accordance with California Health & Safety Code § 1367.241, §1368, and §1368.01 and §10123.191 of the California Insurance Code.

Requests made on an old Alliance PA request form or any other form (including the Medi-Cal TAR request form) will be denied until it is resubmitted on the required form *(Form 61-211, revised 12/16)*.

TIPS FOR SUBMITTING SUCCESSFUL PA REQUESTS:

- Fill out all fields on the PA form. **BOTH sides of this two (2) page form must be submitted**.
- **Submit all relevant clinic notes, consultations, and lab values**. The more understanding we have of the clinical situation, the better the chances for approval.
- Use formulary alternatives (which can be found using the Formulary Lookup Tool at **www.alamedaalliance.org/members/pharmacy-and-drug-benefits**) before submitting a PA Request. For other medications tried, submit dates of therapy and therapeutic outcomes. **We strongly encourage you to also attach clinic or progress notes documenting use of alternative agents.**

PRIOR AUTHORIZATION RESOURCES:

RESOURCE	PHONE NUMBER
Fax number where completed PA forms should be sent	**855.811.9329**
Phone number for the Alliance Pharmacy Department	**510.747.4541**
Phone number for PerformRx Pharmacy Help Desk	**855.508.1713**

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#: (_____)_____**

Plan/Medical Group Fax#: (_____)_____ **Non-Urgent** ☐ **Exigent Circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:

Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_____	Allergies:

Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:

Address:	City:	State:	Zip Code:

Requestor (if different than prescriber):	Office Contact Person:
NPI Number (individual):	Phone Number:
DEA Number (if required):	Fax Number (in HIPAA compliant area):

Email Address:

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?

☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:	☐ Patient's Home	☐ Long Term Care
☐ Physician's Office	☐ Home Care Agency	☐ Other (explain):_____
☐ Ambulatory Infusion Center	☐ Outpatient Hospital Care	_____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

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Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number (_____)_____

☐ Approved ☐ Denied Comments/Information Requested: _____