[**www.CAHealthWellness.com**](http://www.cahealthwellness.com/)

Prescription Drug Authorization Form Contact Information

Please use the Prescription Drug Prior Authorization Request Form (No. 61-211) when submitting prior authorization requests for prescription drugs. A copy of the Prescription Drug Prior Authorization Request Form is available on the Provider Resources webpage at [www.cahealthwellness.com.](http://www.cahealthwellness.com/)

The Prescription Drug Prior Authorization Request Form replaces all existing prescription prior authorization forms used by California Health & Wellness. Requests made with incorrect forms will be returned to the provider or facility for resubmission on the Prescription Drug Prior Authorization Request Form.

When submitting the Prescription Drug Prior Authorization Request Form for California Health & Wellness members, please note the contact information differs based on the type of prior authorization request being made.

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| **Prior Authorization Type** | **Contact** | **Fax** | **Phone** |
| Self-AdministeredNon-Specialty Medications | US Script | 1-866-399-0929 | 1-877-277-0413 |
| Self-Administered Specialty Medications | AcariaHealth | 1-855-217-0926 | 1-855-535-1815 |
| Physician-Administered Specialty Medications | California Health & Wellness Pharmacy Department | 1-877-259-6961 | 1-877-658-0305 |

**PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM**

**Plan/Medical Group Name:**

**Plan/Medical Group Phone#: ( ) Plan/Medical Group Fax#: ( )**

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| **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 request. |
| **Patient Information: This must be filled out completely to ensure HIPAA compliance** |
| First Name: | Last Name: | MI: | Phone Number: |
| Address: | City: | State: | Zip Code: |
| Date of Birth: | Male Female | Circle unit of measureHeight (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 RenewalIf 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 CarePhysician’s Office Home Care Agency Other (explain): Ambulatory Infusion Center Outpatient Hospital Care  |

**PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM**

ID#:

Patient Name:

**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 request.

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| **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-9/ICD-10:** |
|  |  |
| **3. Required clinical information - Please provide all relevant clinical information to support a prior authorization 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 (e.g. formulary tier exceptions) or required under state and federal laws.Attachments |

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| **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**: **Date**:  |
| **Confidentiality Notice**: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents. |
| **Plan Use Only:** Date of Decision: Approved Denied Comments/Information Requested:  |