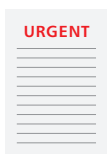


The **Prescription Drug Prior Authorization Request Form** is required for non-Medicare plans per DMHC regulations (Section 1300.67.241).

Please use the fax number below to submit prior authorization requests:

**1(855) 811-9331.**



Both standard and urgent requests should be faxed using the number above. Urgent requests should be clearly labeled **"URGENT"** at the top of the prior authorization request form.

If you have questions call  
**1(888) 989-0091.**

## New Prior Authorization Forms

New Prior Authorization Forms are attached. You can also find them on our website **www.sfhp.org** by selecting:

- Providers Tab >
- Pharmacy & Formulary >
- Prior Authorization Requests >

You can also have the form faxed to you by calling **1(888) 989-0091**

- Select option #2 for providers >
- Then option #1 for Prior Authorization forms >

## Online Prior Authorization Submission URLs

You can also submit an online prior authorization at **www.sfhp.org** and select:

- Providers Tab >
- Pharmacy & Formulary >
- Prior Authorization Requests >

continue to new form

## 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:                                       | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Circle unit of measure<br>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:   |            |   |           |
| <input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request<br>If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____ |            |   |           |
| How did the patient receive the medication?  |            |   |           |
| <input type="checkbox"/> Paid under Insurance    Name: _____   |            | Prior Auth Number (if known): _____   |           |
| <input type="checkbox"/> Other (explain): _____  |            |   |           |
| Dose/Strength:   | Frequency: | Length of Therapy/#Refills:   | Quantity: |
| Administration:  |            |   |           |
| <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____   |            |   |           |
| Administration Location:   |            | <input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care<br><input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____<br><input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> 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.

|   |
|---|
| <b>1. Has the patient tried any other medications for this condition?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO |
|---|

| Medication/Therapy<br>(Specify Drug Name and Dosage) | Duration of Therapy<br>(Specify Dates) | Response/Reason for Failure/Allergy |
|--|--|-------------------------------------|
|  |  |                                     |

|                           |                |
|---------------------------|----------------|
| <b>2. List Diagnoses:</b> | <b>ICD-10:</b> |
|---------------------------|----------------|

|  |  |
|--|--|
|  |  |
|--|--|

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

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:** \_\_\_\_\_

**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/Insurer Use Only:**     Date/Time Request Received by Plan/Insurer: \_\_\_\_\_     Date/Time of Decision \_\_\_\_\_

Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

Approved     Denied    Comments/Information Requested: \_\_\_\_\_