Health Alliance™

Pharmacy/Medical Drug Prior Authorization Form

Important: Use this form when requesting coverage for all drugs covered under either the pharmacy or medical benefit.

Providers are **strongly encouraged** to submit this form and all chart documentation via the Health Alliance Pharmacy Provider Portal. This will result in more reliable communication and expedited notification of determinations. Alternatively, if you are unable to access the portal, fax this form and all chart documentation to (217) 902-9798. If you have questions, please call (800) 851-3379.

☐ **Urgent** means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient's life/health, or the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

Section A - Member Information

Today's Date:	First Name:	Last Name:
Member ID #:	Date of Birth:	Primary Insurance:

Is this a ☐ **new request** or ☐ **a continuation of therapy** or ☐ **a retrospective request for payment**? Start date _____
Were manufacturer samples provided? ☐ **Yes** ☐ **No** If yes, quantity/days of supply _____
Are the drugs being requested as part of a clinical trial? ☐ **Yes** ☐ **No** If yes, list the clinical trial NCT# or FDA issued IND#: _____
Is this patient currently hospitalized? ☐ **Yes** ☐ **No** If yes, include the anticipated discharge date _____

Section B - Requesting Provider Information

First Name:	Last Name:		
Address:	City:	State:	Zip code:
Phone:	Fax:	NPI:	
Specialty:	Email:	Contact Name:	

Participating provider? ☐ **Yes** ☐ **No** If no, do you have an approval to consult and treat? ☐ **Yes** ☐ **No** Auth #_____

Section C - Information for Drugs that are Administered by Provider (not Self-Administered)

Are any of these drugs medical service drugs? ☐ **Yes** ☐ **No** If yes, please answer the next question
The medical service drug(s) will be administered at what type of facility? ☐ **home infusion/long-term care** ☐ **infusion suite/expanded care**
Is the rendering provider information the same as Section B? ☐ **Yes** ☐ **No** If no, you must complete the rest of this section

Facility/Provider Name:			
Address:	City:	State:	Zip code:
Phone:	Fax:	NPI:	

Participating facility/provider? ☐ **Yes** ☐ **No** If no, do you have an approval to consult and treat? ☐ **Yes** ☐ **No**
Auth #_____

Section D - Drug Formulary Exception Requests ***Please include a supporting statement and chart documentation***

Is this a request for any of the following exceptions to any formulary design? ☐ **Yes*** ☐ **No**

- ☐ Non-formulary Exception - Coverage of a drug not currently listed on the formulary.
- ☐ Quantity Exception - Coverage of a quantity of drug greater than the formulary limit.
- ☐ Tiering Exception - Reduce the tier of a formulary drug (Specialty drugs are exempt).
- ☐ Step-Therapy Exception - Request to bypass step therapy requirements.
- ☐ Prior Authorization Exception - The drug-specific prior authorization criteria should not apply to your patient.

Section E - clinical Information of Drug(s) Requested ***Please include chart documentation***

Drug Name & Strength	HCPCS	Qty/Days	Dose Per Administration/Directions for Use/Frequency of Administration

ICD-10 code(s)	Procedure code(s)
Additional information related to the request	

Section F - List All Previous Treatments ***Please include chart documentation***

Drug Name/Therapy	Dates of Use	Reason for Failure

☐ I certify that the information provided is true and accurate to the best of my knowledge.

***The prescriber must submit a written supporting statement which explains why an exception is medically necessary.**

Prescriber's Signature _____ Date _____

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