Florida Health Care Plans

An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA HEALTH CARE PLANS PRIOR AUTHORIZATION MEDICATION FORM

DATE: **AUTH#**

Provider Name	**Provider Signature**	
Specialty	**Provider Phone**	
Contact Person	**Provider Fax**	
Routine ☐	**Urgent** ☐ **Phone: 386-238-3230 *or* 800-352-9824** **If your request is urgent, you must call the Central Referral Dept. prior to submitting your request.**	
Patient Name	**FHCP#**	**DOB**
Patient Home Phone	**Patient Alternate Phone**	
Medication Requested & Duration of Therapy ***(Please specify name, strength, dosing schedule & route of administration)***		
Diagnosis	**ICD10 Code**	**Is this a New Medication** ☐ **or** **Ongoing Medication** ☐
Alternatives Tried:		
Reason for the Medication:		

Please fax completed form with CLINICAL NOTES and MED LIST to FHCP Central Referrals at 386-238-3253 or 877-659-3427

You may view the formulary online at *www.fhcp.com* by clicking on the Provider Tab; then either the Provider Services *or* Forms tab. On the right-hand side, click on **Formulary** under "Related Documents" to determine whether a medication requires prior authorization.

THE SECTION BELOW IS FOR FHCP INTERNAL USE ONLY

☐ **APPROVED BY FLORIDA HEALTH CARE PLANS FOR:**

☐ **CVS Caremark** ☐ **FHCP Pharmacy** ☐ **Provider Office Infusion** ☐ **FHCP Infusion**

Signature:	**Date:**	**Approved / Denied**