

## MEDICATION PRIOR AUTHORIZATION FORM

In accordance with SB866, Effective 1/1/2015 HPSJ will **only** accept the DMHC mandated state-wide prior authorization form (Form 61-211) which can be found on the next page.

Requests made on the old HPSJ Prior Authorization 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).

The form may be found at [www.hpsj.com](http://www.hpsj.com) in the Provider Corner.

### HPSJ Medication Prior Authorization Resources:

Number	Resource
(209) 942-6303 (phone)	<b>Eligibility Verification (IVR)</b> <i>Use Medi-Cal number (first 9 digits including letter) or S.S.N. to obtain HPSJ number</i>
(209) 942-6302 (fax)	<b>Fax number for HPSJ UM Department</b> <i>Fax prior authorization requests and supporting documentation to this number</i>
(209) 942-6340 (phone)	<b>Provider Services</b> <i>General questions or concerns</i>

### Instructions:

1. Complete the attached Prior Authorization Request Form. All fields must be filled out.
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 with supporting documentation to HPSJ at **(209) 942-6302**

### Tips for submitting successful prior authorization requests:

- Fill out **all** fields on the PA form. **BOTH sides of this two page form must be submitted.**
- Submit all relevant clinic notes, consultations, and lab values. The better picture we have of the clinical situation the better the chances for approval.
- Use formulary alternatives (available using the Formulary Lookup Tool at [www.hpsj.com](http://www.hpsj.com)) before requesting prior authorization. Give an adequate trial of formulary alternatives (including dose and duration) before concluding treatment failure.
- For other medications tried, submit dates of therapy and results from those trials (it may be helpful to submit clinic notes documenting use of alternative agents).

### Identify the Filling Pharmacy:

Please identify the filling pharmacy somewhere on the form. This is important in order for HPSJ to notify the pharmacy as soon as possible after a decision has been made. If the pharmacy is filling it out, please use **pharmacy stamp**.

Thank you in advance for your cooperation with this state mandated requirement.

# PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: \_\_\_\_\_

Plan/Medical Group Phone#: (\_\_\_\_\_) \_\_\_\_\_

Plan/Medical Group Fax#: (\_\_\_\_\_) \_\_\_\_\_

<b>Instructions:</b> 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.					
<b>Patient Information: This must be filled out completely to ensure HIPAA compliance</b>					
First Name:		Last Name:		MI:	Phone Number:
Address:			City:		State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____		Allergies:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:		
<b>Insurance Information</b>					
Primary Insurance Name:			Patient ID Number:		
Secondary Insurance Name:			Patient ID Number:		
<b>Prescriber Information</b>					
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:					
<b>Medication / Medical and Dispensing Information</b>					
Medication Name:					
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal 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 <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care   _____			

## PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:
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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.

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

<b>2. List Diagnoses:</b>	<b>ICD-9/ICD-10:</b>

<b>3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization review.</b>
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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

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