2024 PRECERTIFICATION REQUEST FORM

Prescriber:

One or more of your patient's prescriptions requires prior authorization. Please complete the included prior authorization request form for each medication listed below. You will receive a faxed response to each prior authorization request submitted.

Patient Name:

Date of Birth:

Medication(s):

For Office Use Only

VP ☐ SX ☐ PM ☐ SS ☐ EBC ☐

Revised 09/20/2023

2024 Precertification Request Form – Prescription Drug

Please fax the completed form to **833-225-1973**
Prior Authorization Department phone **1-800-838-0007** (physicians and pharmacies only)

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.

◯ **Check if Urgent** *The prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the 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 measure: Height (in/cm): Weight (lb/kg):	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name: VRX	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requester (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (individual):		Fax Number (in HIPAA compliant area):	
E-mail Address:			

Medication/Medical and Dispensing Information

Medication Name:

◯ Dispense as written ◯ Generic substitution permitted

*If neither box is checked, HID will review as "generic substitution permitted"

◯ New Therapy ◯ Renewal

If Renewal | Date Therapy Initiated: Duration of Therapy (specific dates):

Pharmacy Name:

Pharmacy Phone Number: Pharmacy Fax Number:

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity: / 30 days

Administration:

◯ Oral/SL ◯ Topical ◯ Injection ◯ IV ◯ Other:

Administration Location:

◯ Patient's Home ◯ Long Term Care ◯ Physician's Office ◯ Home Care Agency ◯ Ambulatory Infusion Center

◯ Outpatient Hospital Care ◯ Other (explain):

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 request.

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-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	**Current Medication List:**

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:**