INTotal Health
An Inova Health Plan

Pharmacy Pre-Authorization Form

Fax to: 1.855.762.5205

Today's date_____/___/____

WE CAN ONLY PROCESS COMPLETED FORMS

Any incomplete sections will result in a delay in processing.

This medication request form applies only to members of **INTotal Health**. Participating providers should use this form to request authorization for medications for the **pharmacy benefit**. This form is **not** for use for pre-authorization for medical buy and bill. Please call us at 1.877.433.7643 with any questions about medication requests.

1. Please allow at least 24 hours to review this request. If you have any questions regarding the pre-authorization request, you can contact us at 1.877.433.7643. The pharmacy may dispense up to a 72-hour supply while awaiting the outcome of this request. To request a 72-hour supply the pharmacy must contact us at 1.877.433.7643.
2. Access our website at http://provider.intotalhealth.org/content/provider_resources_documents to view our formulary.
3. ICD/diagnosis code is required for all requests.

Review criteria

We review requests for pre authorization on the basis of medical necessity. Some medications may have additional criteria. In those cases the additional questions will be faxed to the requesting provider office. **Copies of office notes and medical records may also be requested.**

We use the following criteria in reviewing medication requests. Documentation is required for approval including name of medication, dates of trial(s) and reason(s) for discontinuation.

1. The use of preferred or formulary drugs is contraindicated in the patient. Please provide reason for contraindication.
2. The patient has failed an appropriate trial of preferred or formulary drugs or related agents.
3. The choices available in the formulary are not suitable for the patient. The selected drug is required for patient safety.
4. The use of a formulary drug may provoke an underlying medical condition, which would be detrimental to care.
5. **For non-formulary drug requests, the requirement is trial of 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative.**

MEMBER INFORMATION

Last name **First Name** **MI**	**Medicaid ID #**	**Date of birth**	**Sex (circle one)** F M
Member's place of residence: ☐Home ☐ Nursing facility **Administration site:** ☐Home ☐ Office ☐ Outpatient facility	**Height**	**Weight**	

PRESCRIBER INFORMATION

Last name **First name** **MI**		**NPI #** (required)	**DEA/License#**
Address where service rendered		**City**	**State**
ZIP code	**Telephone number** ( )	**Fax number** ( )	
Office contact name		**Contact direct phone number**	

PHARMACY INFORMATION

Name	**Pharmacy NPI #**	**Telephone number** ( )	**Fax number** ( )

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CLINICAL INFORMATION

Drug(s) name and strength:	**Diagnosis and/or indication:**	**ICD Code:**
Length of Therapy	**SIG: (dose and frequency)**	

☐**Is there any reason a medication that does not require authorization within the same class be used?** ☐ Yes☐ No
Access our website at **http://provider.intotalhealth.org/content/provider_resources_documents** to view our formulary.

If Yes, did member experience any of the below to medications on formulary that does not require authorization?

☐Allergic response. Medication_____Date & Details_____

☐Adverse reaction - Medication_____ Date & Details_____

Please send copy of completed FDA MedWatch form for allergic or adverse reactions

☐ Inadequate response - Medication_____ Date & Details_____

☐Contraindication - Medication_____ Date & Details_____

☐Drug-Drug interaction - Medication_____ Date & Details_____

☐Patient's condition is clinically stable and changing the medication may cause deterioration of the patient's condition – **How long has member been stable on current medication?**_____

☐**Has any other medications not listed above been tried to treat this condition?** ☐ Yes☐ No.

If Yes, did member experience any of the below to medications tried previously?

☐Allergic response. Medication_____ Date & Details_____

☐Adverse reaction - Medication_____ Date & Details_____

Please send copy of completed FDA MedWatch form for allergic or adverse reactions

☐ Inadequate response - Medication_____ Date & Details_____

☐Contraindication - Medication_____ Date & Details_____

☐Drug-Drug interaction - Medication_____ Date & Details_____

☐Patient's condition is clinically stable and changing the medication may cause deterioration of the patient's condition – **How long has member been stable on current medication?**_____

Describe medical necessity for non-preferred medication(s) or for prescribing outside of FDA labeling:

_____

List all current medications, including dose and frequency:

_____

Other clinical rationale to support use of the requested medication:

DIAGNOSTIC STUDIES AND/OR LABORATORY TESTS PERFORMED

(List all tests done within past 90 days that are related to diagnosis for medication requested.)

LABS:			**DIAGNOSTIC TEST:**		
Test	Date	Result	Procedure	Date	Result

By checking the following box, I certify that applying the standard review time frame may seriously jeopardize my patient's life, health, or ability to attain, maintain, or regain maximum function. ☐Request for urgent review

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber signature (or authorized representative) (STAMP NOT ACCEPTED) Date