Prescription Drug Prior Authorization or Step Therapy Exception Request Form (No. 61-211) Contact Information

Please use the **Prescription Drug Prior Authorization or Step Therapy Exception Request form (No. 61-211)** when submitting prior authorization requests for prescription drugs. The form is attached below and is available on the Health Net* provider library under "Forms and References" at: https://providerlibrary.healthnetcalifornia.com/medi-cal/forms.html. Requests made with incorrect forms will be returned to the provider or facility for resubmission.

When submitting a form for Community Health Plan of Imperial Valley members, please note the contact information differs based on the type of prior authorization request being made.

Prior authorization contact information: Community Health Plan of Imperial Valley

Prior authorization type	Contact	Fax	Phone
Self-administered medication requests	**Medi-Cal Rx**	800-869-4325	800-977-2273
Physician-administered medications	**Pharmacy services**	833-953-3436	800-867-6564 Option 2

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/medical group name: _____ **Plan/medical group phone number:** _____

Plan/medical group fax number: _____ **Non-urgent** ☐ **Exigent circumstances** ☐

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 or step-therapy exception request. **Information contained in this form is Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA).**

Member Information

First name:	Last name:	MI:	Phone number:
Address:	City:	State:	ZIP Code:
Date of birth: ☐ Male ☐ Female	Circle the unit of measure Height (in/cm):____ Weight (lb/kg):____	Allergies:	
Member's authorized representative (if applicable):		Authorized representative phone number:	

Insurance Information

Primary insurance name:	Member ID number:
Secondary insurance name:	Member ID number:

Prescriber Information

First name:	Last name:	Specialty:	
Address:	City:	State:	ZIP Code:
Requestor (if different than prescriber):		Office contact person:	
National provider identifier (NPI) (individual):		Phone number:	
Drug enforcement administration (DEA) (if required):		Fax number (in HIPAA compliant area):	
Email address:			

Medication/Medical and Dispensing Information

Medication name:

☐ New therapy ☐ Renewal ☐ Step therapy exception request
If Renewal: Date Therapy Initiated: Duration of therapy (specific dates):

How did the member receive the medication?
☐ Paid under Insurance Name:_____ Prior auth number (if known):_____
☐ Other (explain):

Dose/strength:	Frequency:	Length of therapy/number refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration location:
☐ Member's home ☐ Long term care
☐ Physician's office ☐ Home care agency ☐ Other (explain):_____
☐ Ambulatory infusion center ☐ Outpatient hospital care

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Member name:	ID number:

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 or step-therapy exception request.

1. Has the member 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 or step-therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if member 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, including information related to exigent circumstances, 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 or electronic ID verification:_____ **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/Insurer Use Only: Date/time request received by plan/insurer:_____ Date/time of decision_____

Fax number_____

☐ Approved ☐ Denied Comments/information requested: _____