AHF

Prescription Drug Authorization Request
Fax Completed Form to (844) 357-2543

Plan Option:
PHP (HMO SNP)
• Routine requests: processed within 72 hrs
PHC-CA
• All requests: processed within 1 business day
PHC-FL
• All requests: processed within 24 hours
AHF   (Eligibility check)

o Please complete **all** sections legibly. Request will be processed within normal timeframes unless noted as an urgent request and the request meets urgent criteria.

o **Include all pertinent clinical documentation.** Failure to do so will result in a delay in processing.

Member Information

_____
Member Name   Birth Date   Member ID Number

Drug Information

Drug _____ Strength _____

☐ New
☐ Refill
Date drug Initiated:

Quantity _____ Directions for Use _____

Diagnosis _____

Duration of Therapy _____ Patient Allergies _____

Previous Therapies: Include Drug, Dose, and Duration

_____

_____

Rationale for Exception Request or Prior Authorization*

○ Contraindication(s) (list conditions):_____

○ Drug Interaction(s) (please specify):_____

○ Medical need for higher dosage: _____

○ All covered drug(s) on formulary contraindicated or previously tried, but with adverse outcome (toxicity, allergy, therapeutic failure):

Explain medical rationale:

_____

_____

***Please provide lab data, discharge summaries, or progress notes as applicable**

Prescriber Information

_____
Prescriber Name (Print)   Signature   Date

_____
Prescriber Office Contact   Phone   Fax

Pharmacy Information

_____
Pharmacy Name   Phone   Fax

For Health Plan Use Only

☐ Approved ☐ Denied ☐ Inquiry   Date of Action_____   Approved through _____

Completed By _____   Reviewed By_____

Comments: _____

Reason for Auth Request
○ PA Required
○ Non-Formulary
○ Early Refill; Reason_____
○ Quantity Limit
○ Other_____

Positive Healthcare Pharmacy Services / Phone (888) 554-1334 / Fax (844) 357-2543