NETWORK MEDICAL MANAGEMENT
1668 South Garfield Ave., 2nd Fl, Alhambra, CA 91801 Phone (626) 282-0288 • Fax (626) 943-6369

To: All Contracted Providers

From: Network Medical Management, MSO

Cc: Albert W. Young, M.D., M.P.H.

Date: June 17, 2015

Re: Prior Authorization Request Form for Prescription and Injectible Drugs

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The enactment of Senate Bill 866 requires us to adopt the use of standardized pharmacy prior authorization form No. 61-211 for all non-Medicare health plans effective January 1, 2015. This form is mandated by the California Department of Managed Healthcare and cannot be altered. All prescription drugs and injectible drugs processed through the Medi-Cal or Commercial benefits, must be submitted on the enclosed form. Any other form of submission will not be accepted.

Attached you will find Form No. 61-211 for your office use. Please submit the completed form to the applicable UM authorization fax number, as shown below.

IPA Network	**Fax Line**
Advantage Health Network	Routine Fax: (626) 442-1106
Arroyo Vista FHC	Routine Fax: (626) 943-6351
Adventist Health Physicians Network - WM	Routine Fax: (626) 943-6398
Adventist Health Physicians Network - GA	Routine Fax: (626) 943-6390
Citrus Valley Independent Physicians	Routine Fax: (626) 943-6362
Greater Orange County Medical	Routine Fax: (909) 595-5867
Greater San Gabriel Valley Physicians	Routine Fax: (626) 943-6394

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#: (_____)_____**

Plan/Medical Group Fax#: (_____)_____

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.

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:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information			
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:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal

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

How did the patient receive the medication?

☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____

☐ Other (explain):

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

Administration:

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

Administration Location:

☐ Patient's Home ☐ Long Term Care

☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____

☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

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-9/ICD-10:**

3. <u>Required clinical information</u> - 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

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**:_____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

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