QualityHealthPlans of new york

Attention: ACTION REQUESTED
Prior Authorization DENIAL may occur unless complete information is provided

Reference: [PA#]

General Prior Authorization Form: New Starts High Risk Medication

FAX COMPLETED FORM TO QHP PHARMACY DEPT. Fax # 877-817-0842

Coverage Criteria:

-Covered Uses: All medically accepted indications not otherwise excluded from Part D.
-Age Restrictions: No Prior Authorization if patient is below age 65.
-Coverage Duration: 12 months
-Other Criteria: Approve for continuation of therapy. If member is age 65 or older, provider acknowledges the risks of using this drug in the age 65 and over population and attests that no other drug can meet the needs of the patient.

Member Information	Prescriber Information	
Patient Name:	Prescriber Name:	
Member ID#	NPI or DEA#:	
DOB:	Office Phone:	Office Fax:
Address:	Address:	
Home Phone:	Contact Person:	

Medication Information	Medical Information
Medication Requested (drug name, strength and route of administration):	Drug Allergies:
Medication Details (frequency, quantity):	Diagnosis:
Expected Length of Therapy:	Prescriber's Signature/Date:
New Prescription OR Date Therapy Initiated:	

Rationale for Prior Authorization

1. Does the prescriber acknowledge the risks of using this drug in the age 65 and over population and attests that no other drug can meet the needs of the patient? (check one) _____Yes _____No
2. Please list other medications attempted for this patient:

Medication:	Reason therapy failed:	Length of therapy:
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Additional comments: _____
_____
_____
4. PLEASE INCLUDE RELEVANT MEDICAL RECORDS AND LAB REPORTS WITH YOUR REQUEST.

For Expedited Requests please call 1-877-233-7058
Our Formulary List is located at http://www.qualityhealthplansny.com