

FLORIDA HEALTH CARE PLANS

PRIOR AUTHORIZATION MEDICATION FORM

Phone: 386-238-3230 / 800-352-9824

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE:** |  | | | **AUTH#:** | | | | | | | | | | | | | |
| Provider Name: | | | | | | | | | | | Provider Signature: | | | | | | |
| Specialty: | | | | | | | | | | | Provider Phone: | | | | | | |
| Contact Person: | | | | | | | | | | | Provider Fax: | | | | | | |
| Routine | | | | **Urgent**   **Phone: 386-238-3230 *or* 800-352-9824**  **If your request is urgent, you must call the Central Referral Department prior to submitting your request. Urgent is serious jeopardy to life, health, maximum function** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Patient Name: | | |  | | | | | | | FHCP #: | |  | | DOB: | |  | |
| Patient Home Phone: | | | | |  | | | | | Patient Alternate Phone: | | |  | | | | |
| Name of Medication | | | | | | Strength | | Dosing Instructions/Route of Administration | | | | | | | | | Duration of Therapy |
|  | | | | | |  | |  | | | | | | | | |  |
| Brand name ONLY **REASON FOR BRAND ONLY:** | | | | | | | | | | | | | | | | | |
| Diagnosis: | |  | | | | | | | ICD10 Code: | | |  | | | | | |
| If infusion or injection, will requesting provider be administering medication?  **WILL THE MEDICATION BE:**  **Provided by Pharmacy**  **Provided by Office** | | | | | | | | | | | | | | | | | |
| Alternatives tried: | | | | | | | | | | | | | | | | | |
| Reason for the Medication: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Please fax completed form with CLINICAL NOTES and MED LIST to FHCP Central Referrals at 386-238-3253 or 855-442-8398**  You may view the formulary online at ***www.fhcp.com*** by clicking on the “For Providers” Link, then click “Resources and Support”, then select “View Member Formularies”, then “Medication Formulary” to determine whether a medication requires prior authorization. | | | | | | | | | | | | | | | | | |
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| ***THE SECTION BELOW IS FOR FHCP INTERNAL USE ONLY*** | | | | | | | | | | | | | | | | | |
| APPROVED BY FLORIDA HEALTH CARE PLANS FOR: | | | | | | | | | | | | | | | | | |
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| CVS Caremark  FHCP Pharmacy  Provider Office Infusion  FHCP Infusion | | | | | | | | | | | | | | | | | |
| **Signature:** | | | | | | | **Date:** | | | | | | | | **Approved / Denied** | | |
|  | | | | | | | | | | | | | | | | | |

10727\_ALL 0921R1 Rev. 8-20-21