

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:       |
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| **Please fax completed form with CLINICAL NOTES and MED LIST toFHCP 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:       |
|  |
|  |
|  [ ]  CVS Caremark [ ]  FHCP Pharmacy [ ]  Provider Office Infusion [ ]  FHCP Infusion |
| **Signature:**  | **Date:**  | **Approved / Denied** |
|  |

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