Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA HEALTH CARE PLANS
PRIOR AUTHORIZATION MEDICATION FORM
Phone: 386-238-3230 / 800-352-9824

Please fax completed form with CLINICAL NOTES and MED LIST to
FHCP Central Referrals at 386-238-3253 or 855-442-8398

Note: If clinical documentation is not received with this request, request may result in a denial.

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.

DATE: **NOTE: ALL BOXES MUST BE COMPLETED FOR REQUEST TO BE REVEIWED**

Provider's Name including credentials:	Provider Signature:
Specialty:	**ADDRESS** and name of office/facility:
Contact Person: Phone/Ext:	Provider Phone: Provider Fax:

Routine ☐	**Urgent** ☐ STOP **Phone: 386-238-3230 *or* 800-352-9824**
	FHCP HAS THE RIGHT TO RECLASSIFY THIS REQUEST TO ROUTINE IF THE DEFINITION OF URGENT IS NOT MET. URGENT IS SERIOUS JEOPARDY TO LIFE, HEALTH, MAXIMUM FUNCTION.
	If your request is urgent, you must call the Central Referral Department prior to submitting your request.

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:**

New Start/Initiation of Therapy Continuation of Therapy

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: