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Capital Health Plan (CHP) Medication Management Services Department

MEDICAL DRUG PRIOR AUTHORIZATION REQUEST FORM

All of the applicable information and supporting documentation is required. Incomplete forms and requests without supporting documentation will be returned.

Date of request _____ # of pages enclosed _____

Member's Name _____

Capital Health Plan ID number _____ Member's Date of Birth _____

Member's Contact Phone Number(s) _____

Submitter's Name _____ Office back line/phone number _____

Office Fax Number _____

Prescribing physician's Name _____

Prescriber's Phone Number _____ Prescriber's Fax number _____

Place of service _____

Date of service _____

Medical drug Name and Strength _____

Directions for use _____

Duration of treatment _____

Diagnosis for which this medication is being ordered _____

Diagnosis code(s) _____

HCPCS - Drug code(s) _____

Has this been previously approved _____ If yes please include most recent approval letter if approval was not with CHP

Fax request to: Capital Health Plan Medication Management Services Department (850)523-7370

Capital Health Plan's Clinical Criteria and formularies are located at www.capitalhealth.com

For assistance, please contact Capital Health Plan's Network Services Department at 850-523-7361.

Capital Health Plan has delegated Prescription Drug Coverage Determinations to Prime Therapeutics
CHP members **(with prescription drug benefits)** in need of prescription drug Coverage Determination please submit the request to Prime Therapeutics by utilizing the forms found at www.capitalhealth.com or through Cover My Meds.