Capital Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association

2140 Centerville Place • PO Box 15349
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www.capitalhealth.com

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) _____
Member's Height_____ Weight_____

Submitter's Name _____ Date of service _____
Office back line/phone number_____ Office Fax Number _____
Prescriber's Name_____
Prescriber's Phone Number _____ Prescriber's Fax number _____
Place 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
For 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.

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.
Provider Signature: _____Date_____