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

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www.capitalhealth.com

Capital Health Plan (CHP) Medication Management Services Department

MEDICAL DRUG PRIOR AUTHORIZATION REQUEST FORM

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

Today's Date _____ # of pages enclosed_____
Member Name _____
Capital Health Plan ID#_____ Member Date of Birth _____
Member Contact Phone # _____
Member Height_____ Weight_____

Submitter Name _____Date of appointment _____
Submitter Phone # and ext_____ Submitter Fax # _____
Prescriber Name_____ NPI _____
Prescriber Phone # _____ Prescriber Fax # _____
Place of service and NPI_____

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) _____
List any other medications patient will use in combination with requested medication:
_____

Has this been previously approved?_____ If yes, include the 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 using 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_____