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) Pharmacy & Therapeutics 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 Pharmacy & Therapeutics 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_____