2140 Centerville Place • PO Box 15349
Tallahassee • FL • 32317-5349
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____________________