

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** _____