Request for Prior Authorization Approval for Coverage of an Excluded/Limited Drug

MEDICAL NECESSITY REVIEW

EMPLOYEE SECTION

To request coverage for an excluded/limited prescription drug or a medication not covered under the formulary, this form must be completed by the Employee and Treating Physician. Approval is required prior to Plan payment and is based on medical necessity and other plan design features. The Plan will notify the employee upon completion of the review and any limitations that may apply. All approvals and reviews are subject to Plan changes and are limited to a maximum of one year.

Employee Name _____ Phone Number _____

Employee SS # _____ Work Phone/Ext _____

Office/Dept. _____ Group No. _____ ☐ Patient at Wood County Health Center

_____ _____

Employee's Signature (Retain a copy for your records) Date

PHYSICIAN SECTION

Patient Name _____ Patient Birth Date _____

Patient's Relationship to Subscriber _____

Name of drug requested for approval: _____

Dosage _____ **Quantity** _____ **Days Supply** _____

Prescription Duration: _____

Identify if utilizing a drug discount program/coupon for this medication: ☐ Yes ☐ No

Medical Condition _____

Medical History _____

Type of Treatment _____

Formulary Alternatives Tried _____

Other Medications/Therapies tried and reason(s) for failure and/or any other information in addition to the office notes/history. Include any previous or current therapy related to the diagnosis, using drug names and dates.

_____

_____

Must provide <u>all</u> office notes/history to assist with medical necessity determination including compliance with treatment plan. Include length of trial and/or if samples were given. Incomplete data results in denial of request.

Treating Physician Name _____

Physician Phone _____ Physician Fax _____

_____ _____

Treating Physician's Signature Date

Send completed form via <u>secure e-mail to</u> benefitclerk@woodcountyohio.gov <u>or</u> confidential fax to 419-353-7429.

PLEASE PRINT OR TYPE

FOR PLAN USE ONLY

☐ Additional information required. Information requested _____

☐ Not Approved ☐ Not Approved: Incomplete Form/Supporting Documentation

☐ Approved from _____ to _____ (Not to exceed one year.)
Co-Payment: $20 plus 50% of AWP to a maximum of $200. Contact the Plan to learn more about lowering this co-payment.

- ☐ **Health Third Party Administrator: Pay for administration cost only.**
- ☐ Purchase is permitted at lowest price point pharmacy: _____
- ☐ Prescription is over $1,000. Estimated cost prior to coverage _____
- ☐ Maximum number of prescription fills per approved timeframe _____

Notified/Copied to employee on _____ **Program Administrator** _____ **Date** _____