



6450 US Highway 1, Rockledge, FL 32955

Additional copies of this form can be found on the HFHP Provider Portal Website located at: <https://myhfhp.health-first.org>

Pharmacy Authorization / Exception Form

Customer Service

Phone: (321) 434-5665
Toll Free: (800) 716-7737
TDD Relay: (800) 955-8771

FAX COMPLETED FORM AND SUPPORTING DOCUMENTATION
TO: **(321) 434- 4752**

ALL REQUESTED INFORMATION MUST BE PROVIDED FOR CONSIDERATION FOR COVERAGE.

PLEASE TYPE OR PRINT CLEARLY

Step 1: Patient & physician information	<u>Patient Information</u>		<u>Requesting Physician Information</u>		<u>Performing Physician Information</u>	
	First Name: _____ Last Name: _____ DOB: ____/____/____ Health First ID #: _____		Physician Name: _____ Contact Person: _____ Phone: (____) _____ Ext. ____ Fax: (____) _____		<input type="checkbox"/> Check here if same as requesting Physician Name: _____ Phone: (____) _____ Fax: (____) _____	
Step 2: Diagnosis and Medical Information	Drug Name:		Strength and Route of Administration:		Dosage/ Frequency:	
	Qty:	Place OF Service: ? Physicians Office ? Pharmacy ? Home Agency	Expected Length of Therapy:		HCPCS Code:	? New Prescription OR Date Therapy Initiated:
	Drug Allergies (if applicable):		Diagnosis: _____ ICD-9 Code: _____			
Step 3: Rationale for Exception Request or Prior Authorization	<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) ® Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);					
	<input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change ® Specify below: Anticipated significant adverse clinical outcome <input type="checkbox"/> Other: Explain below REQUIRED EXPLANATION: _____ _____ _____					
<input type="checkbox"/> Please check here if the patient is receiving this medication as part of a clinical trial						

Request for Expedited Review

CRITERIA FOR EXPEDITED REVIEW: IF WAITING FOR A DECISION IN THE STANDARD TIMEFRAME COULD SERIOUSLY HARM THE MEMBER'S LIFE, HEALTH OR ABILITY TO REGAIN MAXIMUM FUNCTION, YOU CAN ASK FOR AN EXPEDITED (FAST) DECISION. CHECK HERE IF YOU ARE REQUESTING A FAST DECISION AS DESCRIBED BY THE CRITERIA ABOVE

HFHP Only	<input type="checkbox"/> Approved: Authorization Number: _____ Authorization Expiration Date: ____/____/____
	Additional Information Needed: <input type="checkbox"/> Office notes <input type="checkbox"/> Clinical information <input type="checkbox"/> Diagnosis code <input type="checkbox"/> Member ID # <input type="checkbox"/> Member name <input type="checkbox"/> Physician name <input type="checkbox"/> Patient height and weight <input type="checkbox"/> Other: _____
	Completed by: _____ Date: ____/____/____ Phone: (321) _____ - _____ (Authorized Health First Health Plans Signature)

USE OF THIS FORM DOES NOT GUARANTEE ELIGIBILITY OF COVERAGE AND DOES NOT SUPERCEDE ANY MEMBER BENEFIT PLAN LIMITATIONS OR THE PROVIDER'S CONTRACTUAL LIMITATIONS.

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AFFIRMATIVE STATEMENT: UM decision making is based only on appropriateness of care and service and existence of coverage. HFHP does not reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.