Simply Healthcare Plans, Inc.
Clear Health Alliance
Medicaid Managed Care

Florida Pharmacy Prior Authorization Form

Instructions:

1. Complete this form in its entirety. Any incomplete sections will result in a delay in processing.
2. We review requests for prior authorization (PA) based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Simply Healthcare Plans, Inc. and Clear Health Alliance, including current member eligibility, other insurance and program restrictions. We will notify the provider and the member's pharmacy of our decision.
3. To help us expedite your Medicaid authorization requests, please fax all the information required on this form to **1- 877-577-9045** for retail pharmacy or **1-844-509-9862** for medical injectables.
4. Allow us at least 24 hours to review this request. If you have questions regarding a Medicaid PA request, call us at **1-844-405-4296**. The pharmacy is authorized to dispense up to a 72-hour supply while awaiting the outcome of this request.
5. Access our websites at **www.simplyhealthcareplans.com/providerCHA** and **www.clearhealthalliance.com/provider** to view the *Preferred Drug List*.
6. An ICD/diagnosis code is required for all requests. An HCPCS billing code is required for all medical injectable/oncology requests. If the billing facility is different from the requesting physician, the billing facility information will need to be completed.

Member information

Last name:	First name:	MI:	Member ID:	Date of birth:	Sex (Circle one): F M
Member's place of residence: ☐Home ☐ Nursing facility Administration site: ☐Home ☐Office ☐Outpatient facility			Height:	Weight:	

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Medication information

Drug name and strength requested:	SIG (dose, frequency and duration):	HCPCS billing code:
Diagnosis and/or indication:		ICD code:

Has the member tried other medications to treat this condition?	Drug(s) name and strength:	
	Date range of use:	SIG (dose and frequency):
☐**Yes.** Provide this information in the area to the right. You may be asked to provide supporting documentation such as copies of medical records, office notes or completed *FDA Medwatch* form. ☐**No.** Explain why not: _____ _____ _____ _____	Did the member experience any of the below? ☐ Adverse reaction ☐Inadequate response ☐Other Briefly describe details of adverse reaction, inadequate response or other in the space provided below. _____ _____ _____ _____ _____ _____ _____ _____	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:
_____
_____

List all current medications, including dose and frequency:
_____
_____

Other pertinent information:
_____
_____

Diagnostic studies and/or laboratory tests performed

List all tests done within the past 30 days related to the diagnosis of the medication requested.

Labs:				Diagnostic tests:		
Test:	Date:	Result:		Procedure:	Date:	Result:

Prescriber information

Last name:	First name:	MI:	NPI (required):	DEA/license number:
Address where service was rendered:			City:	State:
ZIP code:	Telephone number: ( )		Fax number: ( )	
Office contact name:			Contact direct phone number: ( )	

Billing facility information

Name:		NPI/tax ID (required):	DEA/license number:
Address:		City:	State:
ZIP code:	Telephone number: ( )	Fax number: ( )	
Office contact name:			

Pharmacy information

Name:	Pharmacy NPI:
Telephone number: ( )	Fax number: ( )

Signature

I certify the information provided is accurate and complete to the best of my knowledge, and I understand any falsification, omission or concealment of material may be subject to civil or criminal liability.

_____ _____

Prescriber's signature (or authorized representative) Date