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

Prior Authorization Form for Medical Injectables

This prior authorization (PA) form and PA criteria may be found on our provider websites at **www.simplyhealthcareplans.com/provider** and **www.clearhealthalliance.com/provider**. If the following information is not complete, correct and/or legible, the PA process can be delayed. Please use one form per member. Please allow Simply Healthcare Plans, Inc. and Clear Health Alliance at least 24 hours to review this request. For telephone requests or questions, please call **1-844-405-4296**. **Fax this completed form to 1-844-509-9862.**

Member information:

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

Prescriber information:

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

Medication information:

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

<table>
<tr><td rowspan="3">Has the member tried other medications to treat this condition?

☐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.
• A completed FDA Medwatch Form.

☐No. Explain why not:
____
____
___________________________________</td><td colspan="2">Drug name(s) and strength:</td></tr>
<tr><td>Date range of use:</td><td>Sig code: (dose and frequency)</td></tr>
<tr><td colspan="2">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.
____
____
____</td></tr>
</table>

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 that are related to diagnosis of medication requested.)

Labs			**Diagnostic tests**		
Test	Date	Result	Procedure	Date	Result

Signature:

____

Prescriber’s signature (required) Date

By signature, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission or concealment of material may be subject to civil or criminal liability.