COMMUNITY Health Options™

Medication Prior Approval Form

Submit authorization requests via: Provider Portal (preferred): Provider.HealthOptions.org
Health Options (Medical Management): Fax: (877) 314-5693 Phone: (855) 542-0880

Effective date: 1/1/2023

Member Information (*Denotes Required Field)		
*Patient Name:	*☐ Male *☐ Female	*DOB:
*Health Insurance ID#:	Other Health Insurance (please specify):	
Address:	Phone:	
Patient Weight:	Patient Height:	

☐ **Routine** ▸ Routine Pre-Service requests will generally be processed within 72 hours or two business days, whichever is earliest, upon receipt of all medically necessary information.

☐ **Urgent** ▸ Urgent Pre-Service requests will generally be processed within one calendar day of receipt of all necessary information. Urgent requests are based on clinical presentations that could seriously jeopardize the Member's life or health, ability to regain maximum function, or subjects the Member to severe pain that cannot be adequately managed without the requested care or treatment. To initiate urgent referrals by phone 24/7 call (855) 542-0880.

Emergency services (911 ambulance transport and ED evaluation/treatment) do not require Prior Approval.

Provider Information	
***Requesting/Ordering Provider:**	***Servicing/Rendering Provider or Facility Same as Requesting/Ordering Provider**
*Name:	*Name:
*Address:	*Address:
*Tel:	*Tel:
*Fax:	*Fax:
*Contact Person:	*Specialty:
*Contact Tel:	*NPI:
*NPI	Please list additional provider information, if applicable, to include name, NPI & location.
Clinical Summary or clinical notes must be attached. Incomplete information may delay decision process. Note: If medication is dispensed by a pharmacy, authorization requests go through Express Scripts (Pharmacy Benefit).	

Diagnosis Information (*Denotes Required Field)
*ICD10 (List codes AND brief description):
1.
2.
3.
4.
5.
6.

continued

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Planned Procedure Information (*Denotes Required Field)

***Procedure/Service requested (list all CPT/HCPC Codes AND Description required). Provide National Drug Code (NDC) if available at time of request.**

☐ **Out-of-network (OON) services**

For all OON Services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage.

HCPCS/NDC Code	Description	# of Units Per Dose	Frequency	# of Visits
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

If dose or frequency is higher than FDA/compendia standards, provide supporting clinical rationale to inform the medical necessity review.

Home infusion is preferred when medically acceptable. Has home infusion been discussed with patient?

Out-of-network (OON) services For all OON Services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage.

***Date of first Dose:**

Start: **end:**

Note: Approval duration time may be limited to 60 days in some circumstances.

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