CDPHP Prior Authorization/ Medical Exception Request Form

Fax or mail this form back to:
CDPHP Pharmacy Department, 500 Patroon Creek Blvd., Albany, New York 12206-1057
Phone: (518) 641-3784 • Fax: (518) 641-3208

Patient Information

Last Name: ______________________ First Name: ______________________

Member ID #: ______________________ Date of Birth: ______________________

Please check one: ◯ Medicare ◯ Select Plan (Medicaid) ◯ Other Plan Type __________

Pharmacy and Phone *(if known)*: ______________________

Drug Information

Drug Requested: ______________________ Strength: ______________________

Dosing Regimen: ______________________

Questions

1. Has the patient previously received this drug? . . . . ◯ Yes ◯ No
   How long has the patient been on this drug? ______________________
2. If this patient had a documented allergy/adverse reaction on formulary medications, describe:
   ____
   ____
   ____
3. Document prior therapy and outcomes of each therapy. *(Include details of dose and duration of therapy)*
   ____
   ____
   ____
4. Patient Diagnosis: ______________________
   Diagnosis Code *(required)*: __________
5. Describe patient-specific medical rationale: ______________________
   ____
   ____
   ____

• Please complete the corresponding section for the specific drug/drug classes listed below if applicable •

For celecoxib request:

1. Short term use (30 days or less) pre/post a surgical procedure? . . . . ◯ Yes ◯ No
2. Patient also utilizing oral steroids, anticoagulant or antiplatlet? . . . . ◯ Yes ◯ No
3. Patient history of GERD, gastric/duodenal ulcer/bleed? . . . . ◯ Yes ◯ No

For a reproductive endocrinology drug request:

1. Treatment request is being used for such as timed intercourse or IUI: ______________________
2. Prior number of cycles medication used for: ______________________
3. Dates of prior treatments: ______________________
4. Outcome of prior treatments: ______________________

For Xolair (omalizumab) request:

1. IgE level and date of test: ______________________
2. Does the patient currently use any tobacco products? .... ◯ Yes ◯ No
3. Allergic sensitivity including type of test conducted: ______________________

For Procrit, Epogen or Aranesp:

1. Hemoglobin (Hgb) (g/dl) and date of test: ______________________
2. Hematocrit (Hct) (%) and date of test: ______________________
3. Ferritin (ng/ml) and date of test: ______________________
4. Transferrin saturation (TSAT) (%) and date of test: ______________________

For weight management drug request:

1. Height: ______________________
2. Weight and date taken: ______________________
3. Comorbidities (hypertension, diabetes, hyperlipidemia, etc): ______________________
4. Diet and exercise history: ______________________

For Androgel or Androderm request:

1. Symptoms being treated: ______________________
2. Dates and results of two early morning total testosterone levels (ng/dl): ______________________

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Practitioner Information

Practitioner Signature: ______________________

Practitioner Name: ______________________

EIN: ______________________

Address: ______________________

____

____

Practitioner Phone #: ______________________

NPI #: ______________________

Fax # (for fax notification): ______________________

Nurse Contact: ______________________ Ext. ________

Date of Request: ______________________

Please note: All chart notes, including documentation of samples given, and lab data noted on this form may be requested for documentation of accuracy prior to a determination being rendered. Failure to respond to requests for such additional documentation or additional necessary information may result in the request being denied.

CDPHP reserves the right to review and audit charts as defined in the Participating Physician Agreement, Section 12.3.