

Prescription Drug Authorization Form Contact Information



Please use the **Prescription Drug Prior Authorization Request Form (No. 61-211)** when submitting prior authorization request for prescription drugs. A copy of the **Prescription Drug Prior Authorization Request Form** is attached. The form is also available on the Provider Resources webpage at www.cahealthwellness.com. Requests made with incorrect forms will be returned to the provider or facility for resubmission on the **Prescription Drug Prior Authorization Form**.

When submitting a **Prescription Drug Prior Authorization Request Form** for California Health & Wellness members, please note the contact information differs based on the type of prior authorization request being made.

Prior Authorization Contact Information

Prior Authorization Type	Contact	Fax	Phone
Self-Administered Medications (Including CCIPA)	Envolve Pharmacy Solutions	1-866-399-0929	1-877-277-0413
Physician-Administered Medications	California Health & Wellness Pharmacy Department	1-877-259-6961	1-877-658-0305
CCIPA Physician-Administered Medications (only for chemotherapy, including adjunctive therapy, and transplant immunosuppression).	California Health & Wellness Pharmacy Department	1-877-259-6961	1-877-658-0305
CCIPA Physician-Administered Medications (except for chemotherapy, including adjunctive therapy, and transplant immunosuppression).	Community Care IPA (CCIPA)	1-562-766-2001	1-855-900-1224

Pharmacy Help Desk

1-844-276-1398

NOTE: Enteral Nutrition

- Submit **Pump Enteral Nutrition Prior Authorizations to California Health & Wellness Pharmacy Department**. Billing must be through California Health & Wellness Medical Billing.
- Submit **Bolus (no pump) Enteral Nutrition Prior Authorizations to Envolve Pharmacy Solutions**. Billing must be handled through a network pharmacy using pharmacy claims.

1-877-658-0305

Monday to Friday 8 a.m. to 5 p.m. (PST)

www.CAHealthWellness.com

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____ Plan/Medical Group Phone#: (_____) _____
 Plan/Medical Group Fax#: (_____) _____ Non-Urgent Exigent Circumstances

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:		City:	State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:
Address:		City: State: Zip Code:
Requestor (if different than prescriber):		Office Contact Person:
NPI Number (individual):		Phone Number:
DEA Number (if required):		Fax Number (in HIPAA compliant area):
Email Address:		

Medication / Medical and Dispensing Information

Medication Name:			
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____			
How did the patient receive the medication?			
<input type="checkbox"/> Paid under Insurance Name: _____		Prior Auth Number (if known): _____	
<input type="checkbox"/> Other (explain): _____			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
Administration:			
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____			
Administration Location:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care	

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:
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Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy
2. List Diagnoses:		ICD-10:
3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.		
<p>Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.</p> <p><input type="checkbox"/> Attachments</p>		

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer: _____ Date/Time of Decision: _____

Fax Number (_____) _____

Approved Denied Comments/Information Requested: _____