PROVIDER*Update*

Health Net®

CONTRACTUAL | JULY 15, 2014 | UPDATE 14-283 | 3 PAGES

Prescription Drug Prior Authorization Request Form

Senate Bill (SB) 866 (ch. 628, 2011) established requirements for the development and use of a standardized medication prior authorization request form and for expedited medication authorization processes. Pursuant to these requirements, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) have developed the attached Prescription Drug Prior Authorization Request Form for use by all California health care service plans, insurers and prescribing providers.

Effective October 1, 2014, Health Net is implementing use of the Prescription Drug Prior Authorization Request Form for members with prescription medication benefits enrolled in HMO, Point of Service (POS), PPO, EPO, and Medi-Cal plans. The form must be completed and submitted for prior authorization prescription requests. Health Net processes medication authorization requests within two business days (not exceeding 72 hours for urgent requests) for HMO, POS, PPO, and EPO members. Medication authorization requests for Medi-Cal members continue to be processed within 24 hours or one business day.

SUBMITTING REQUESTS

The form is available on the Health Net provider website at provider.healthnet.com under *Pharmacy Information,* and in the Provider Library under *Forms.* All form fields must be completed in order for Health Net to process the request for authorization. Submit the completed Prescription Drug Prior Authorization Request Form to Health Net Pharmaceutical Services (HNPS) by secure fax to (800) 314-6223 for HMO, POS, PPO, and EPO plans, and (800) 977-8226 for Medi-Cal plans.

ADDITIONAL INFORMATION

Relevant sections of Health Net's provider operations manuals have been updated. The provider operations manuals are available electronically in the Provider Library, located on Health Net's provider website at provider.healthnet.com.

If you need additional information or have questions regarding the form, contact the HNPS Pharmacy Help Desk as follows:

- HMO, POS, PPO, and EPO plans – (800) 548-5524, option 3
- Medi-Cal plans – (800) 867-6564, option 2

Provider Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print the articles of interest. Health Net posts new articles each week that cover a variety of topics, such as health plan updates, administrative procedure reminders, quality improvement tips, and health care initiatives.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ● HMO/POS
- ● PPO
- ● EPO
- ○ Medicare Advantage (HMO/PPO)
- ○ Cal MediConnect
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ○ Molina
  - ● Riverside
  - ● Sacramento
  - ● San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES

provider_services@healthnet.com
HMO/POS, PPO & EPO – (800) 641-7761
Medi-Cal – (800) 675-6110
CommunityCare Covered California – (888) 926-2164

www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#: (_____)_____**
Plan/Medical Group Fax#: (_____)_____

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 request.

Patient Information: This must be filled out completely to ensure HIPAA compliance			
First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ 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:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Patient's Home ☐ Long Term Care
☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

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 request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization review.

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 (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

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:_____ **Date**:_____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

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