Santa Clara
Family Health Plan
The Spirit of Care

To: Santa Clara Family Health Plan Providers and Pharmacies

From: Jennifer Clements, Director of Provider Services
Johanna Liu, Pharm.D., Director of Pharmacy

Date: December 9, 2014

Subject: **Universal Pharmacy Prior Authorization (PA) Form per Senate Bill (SB) 866**

Dear SCFHP Provider:

Effective January 1, 2015 Santa Clara Family Health Plan (SCFHP) will ONLY be accepting a universal pharmacy PA form as required by SB 866.

- This new pharmacy PA form can be found on our website at www.scfhp.com/for-providers/forms and is attached to this memo.
- We will continue to accept all types of pharmacy PA forms until December 31, 2014.
- Beginning on January 1, 2015 all pharmacy PAs submitted using any other form besides the universal pharmacy PA form specified by SB 866 will NOT BE ACCEPTED.

Please transition to the new form as soon as possible. Thanks in advance for your help in contributing to the best patient experience.

Regards,

Santa Clara Family Health Plan

Santa Clara Family Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: Santa Clara Family Health Plan

Plan/Medical Group Phone#: (408) 874-1796

Plan/Medical Group Fax#: (408) 874-1444

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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