Pharmacy Authorization / Exception Form

Health Plans

Customer Service
Toll Free: 1.844.522.5282
TDD Relay: 1.800.955.8771
6450 US Highway 1
Rockledge, FL 32955

Additional copies of this form can be found in our public website located at: myHFHP.org

FAX COMPLETED FORM AND SUPPORTING DOCUMENTATION TO:
1.855.328.0061

Type of Request:

- ☐ Prior Authorization
- ☐ Non-Formulary Medication
- ☐ Quantity Limit Exception
- ☐ Step Therapy Exception
- ☐ Tiering Exception

Important: If previous coverage determination was Denied, please follow the Appeals Process located in our secure provider portal located at: myHFHP.org/login

Failure to complete this form in its entirety, including: Rationale for Exception Request, Required Explanation, and supporting clinical documentation, may result in delayed processing or an adverse determination for insufficient information.

Step 1: Patient & physician information

Patient Information	Requesting Physician Information
First Name:____________________	**Physician Name:** ____________________
Last Name:____________________	**Contact Person:** ____________________
DOB: _______/_________/____________	**Phone:** (______) ____________ **Ext.**__________
Health First ID #: :____________________	**Fax:** (_______) ____________________

Step 2: Diagnosis and Medical Information

Drug Name:		**Strength & Route of Administration:**	**Dosage/ Frequency:**
Qty:	**HCPCS Code:**	**Expected Length of Therapy:**	**Place of Service:** ☐ Member picking up at the Pharmacy ☐ Physician is Buying and Billing
Drug Allergies (if applicable):		**Diagnosis related to request**:____________________ **ICD dx Code:** ____________________	

Step 3: Rationale for Exception Request or Prior Authorization

Attach Supporting Clinical Notes

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure)
→ **Specify below**: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change;
→ **Specify below**: Anticipated significant adverse clinical outcome;

☐ Other: Explain below;

REQUIRED EXPLANATION: ____

____

☐ Please check here if the patient is receiving this medication as part of a clinical trial

Request for Expedited Review

EXPEDITED REVIEW TIMEFRAME IS 24 HOURS.

CRITERIA FOR EXPEDITED REVIEW: IF WAITING FOR A DECISION IN THE STANDARD TIMEFRAME COULD SERIOUSLY HARM THE MEMBER'S LIFE, HEALTH OR ABILITY TO REGAIN MAXIMUM FUNCTION, YOU CAN ASK FOR AN EXPEDITED (FAST) DECISION.

CHECK HERE IF YOU ARE REQUESTING A FAST DECISION THAT MEETS THE CRITERIA ABOVE: ☐

USE OF THIS FORM DOES NOT GUARANTEE ELIGIBILITY OF COVERAGE AND DOES NOT SUPERCEDE ANY MEMBER BENEFIT PLAN LIMITATIONS OR THE PROVIDER'S CONTRACTUAL LIMITATIONS.

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Health First Health Plans does not reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

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