CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form

Horizant

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:		Provider NPI #:
Patient Name:		CCHP Member ID Number:		Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	If ongoing, provide date started:	If medication is ongoing, did the member show improvement while on therapy?	☐ **Yes** ☐ **No**

Please indicate the diagnosis on the left and complete the corresponding questions.

☐ **Restless Leg Syndrome**	Has the member tried pramipexole at a dose of at least 0.5mg per day?	☐ **Yes** ☐ **No**
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
	Has the member tried ropinorole at a dose of at least 4mg per day?	☐ **Yes** ☐ **No**
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
	Has the member tried gabapentin at a dose of at least 1800mg per day?	☐ **Yes** ☐ **No**
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
☐ **Postherpetic Neuralgia**	Has the member tried gabapentin at a dose of at least 1800mg per day?	☐ **Yes** ☐ **No**
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
	Has the member tried a tricyclic antidepressant?	☐ **Yes** ☐ **No**
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
☐ **Other**	Please provide the member's diagnosis:	
	Date of diagnosis?	

History of medications previously tried and failed

Medication Trial/ Previous Therapy	Dates of Therapy		Strength	Frequency	List Adverse Reactions/ Side Effects/ Reason For Discontinuing
	Start Date	End Date			

Please provide any additional information which should be considered in the space below: