CHORUS
COMMUNITY HEALTH PLANS

Pharmacy Prior Authorization Form

Prior Authorization Form for Chorus Community Health Plans Members

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 AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**		
Provider First Name:	**Provider Last Name:**		
Provider Phone:	**Provider Fax:**	**Provider NPI #:**	
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Qty Dispensed (# of units):**

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

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

Diagnosis:

Please indicate place of administration:

❑ Physician's Office ❑ Hospital/Facility ❑ Patient Home ❑ Other

Please provide hospital/facility information:
Name: _____
Phone #: _____
Address: _____
_____

Will the drug be: (select one)
❑ Billed medically using a JCODE
JCODE: _____
❑ Billed at a pharmacy

HISTORY OF MEDICATIONS USED TO TREAT THE ABOVE CONDITION

(*SPECIFIC CLINICAL INFORMATION IS ESSENTIAL TO DETERMINE WHETHER THIS MEDICATION CAN BE APPROVED*)

Have other medications been used in the past to treat this condition? ❑**Yes** ❑**No**

If yes, please provide the following information for ALL past medications tried:

Medication Name	Start Date	End Date	Strength	Frequency	Reason for failure, discontinuation

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