COMMUNITY Health Options®

Medication Prior Approval Form

Prior Approval requests should be submitted through the provider portal at Provider.HealthOptions.org. For urgent Prior Approval requests, call (855) 542-0880. If you are unable to submit a Prior Approval request through the portal, please send via fax at (877) 314-5693.

Member Information * Denotes required field					
*Patient Name	☐ *Male ☐ *Female	*Date of Birth	Weight	Height	Phone
*Health Insurance ID #	Other Health Insurance (Please specify)		Address		

☐ **Routine** – Routine pre-service requests will generally be processed within 72 hours or two business days, whichever is earliest, upon receipt of all medically necessary information.

☐ **Urgent** - Urgent Pre-Service requests will generally be processed within one calendar day of receipt of all necessary information. Urgent requests are based on clinical presentations that could seriously jeopardize the Member's life or health, ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment. To initiate urgent referrals by phone 24/7 call (855) 542-0880.

Emergency services (911 ambulance transport and ED evaluation/treatment) do not require Prior Approval.

Provider Information	
***Requesting/Ordering Provider**	***Servicing/Rendering Provider or Facility**
*Name	*Name
*Address	*Address
*Phone	*Phone
*Fax	*Fax
*Contact Person	*Specialty
*Contact Phone	*NPI
*NPI	Please list additional provider information, if applicable, to include name, NPI & location.
Clinical Summary or clinical notes must be attached. Incomplete information may delay the decision process. Note: If medication is dispensed by a pharmacy, authorization requests go through Express Scripts (Pharmacy Benefit).	

Diagnosis Information
*ICD10 (List codes and description):
1.
2.
3.
4.
5.

Planned Procedure Information
*Procedure/service requested (list all CPT/HCPC codes and description required). Provide the National Drug Code (NDC) if available at the time of request. ☐ **Out-of-network (OON) services** For all OON Services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage

HCPCS/NDC Code	Description	# of units per dose	Frequency	# of visits
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

If dose or frequency is higher than FDA/compendia standards, provide supporting clinical rationale to inform the medical necessity review.
Home infusion is preferred when medically acceptable. Has home infusion been discussed with the patient?
For all out-of-network services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage.
*Date of first Dose: Start: End:

Note: Approval duration may be limited to 60 days in some circumstances.

Submit authorization requests via: Provider Portal (preferred): Provider.HealthOptions.org
Health Options (Medical Management): Fax: (877) 314-5693 Phone: (855) 542-0880

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