# CDPHP Prior Authorization/ Medical Exception Request Form

*Fax or mail this form back to:*
CDPHP Pharmacy Department, 500 Patroon Creek Blvd., Albany, New York 12206-1057
Phone: (518) 641-3784 • Fax: (518) 641-3208

**Patient Information**

Last Name: ____________________ First Name: ____________________

Member ID #: ____________________ Date of Birth: ____________________

Please check one: ◯ Medicare ◯ Select Plan (Medicaid) ◯ Other Plan Type __________

Pharmacy and Phone *(if known)*: ____________________

**Drug Information**

Drug Requested: ____________________ Strength: ____________________

Dosing Regimen: ____________________

Servicing Provider/Facility (for medical benefit drugs) if different from requesting provider:

____________________ TAX ID#/NPI (of facility): ____________________

**Questions**

1. Has the patient previously received this drug? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ◯ Yes ◯ No
   How long has the patient been on this drug? ____________________
2. If this patient had a documented allergy/adverse reaction on formulary medications, describe:
   ____________________
   ____________________
   ____________________
3. Document prior therapy and outcomes of each therapy. *(Include details of dose and duration of therapy)*
   ____________________
   ____________________
   ____________________
4. Patient Diagnosis: ____________________
   ____________________
   ____________________
   ____________________
   Diagnosis Code *(required)*: __________
5. Describe patient-specific medical rationale: ____________________
   ____________________
   ____________________
   ____________________

**• Please complete the corresponding section for the specific drug/drug classes listed below if applicable •**

For high-risk medications in the elderly (e.g., amitriptyline, cyclobenzaprine, doxepin, estrogens, eszopiclone, hydroxyzine, promethazine, zolpidem):

1. Does the provider acknowledge that the benefits outweigh the risks for this patient? ◯ Yes ◯ No

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**CDPHP Prior Authorization/Medical Exception Request Form** *(continued)*

For a reproductive endocrinology drug request:

1. Treatment request is being used for such as timed intercourse or IUI: ____________
2. Prior number of cycles medication used for: ____________
3. Dates of prior treatments: ____________
4. Outcome of prior treatments: ____________

For Xolair (omalizumab) request:

1. IgE level and date of test: ____________
2. Does the patient currently use any tobacco products? . . . . . . . . . . . . . . . . . . . . . . . ◯ Yes ◯ No
3. Allergic sensitivity including type of test conducted: ____________

For Procrit, Epogen or Aranesp:

1. Hemoglobin (Hgb) (g/dl) and date of test: ____________
2. Hematocrit (Hct) (%) and date of test: ____________
3. Ferritin (ng/ml) and date of test: ____________
4. Transferrin saturation (TSAT) (%) and date of test: ____________

For weight management drug request:

1. Height: ____________
2. Weight and date taken: ____________
3. Comorbidities (hypertension, diabetes, hyperlipidemia, etc): ____________
4. Diet and exercise history: ____________

For Androgel or Androderm request:

1. Symptoms being treated: ____________
2. Dates and results of two early morning total testosterone levels (ng/dl): ____________

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**Practitioner Information**

Practitioner Signature: ____________

Practitioner Name: ____________ Practitioner Phone #: ____________

EIN: ____________ NPI #: ____________

Address: ____________ Fax # (for fax notification): ____________

____________ Nurse Contact: ____________ Ext. ______

____________ Date of Request: ____________

***Please note: In order for this request to be considered complete, all sections must be filled in. All chart notes, including documentation of samples given, and lab data noted on this form may be requested for documentation of accuracy prior to a determination being rendered. Failure to respond to requests for such additional documentation or additional necessary information may result in the request being denied.***

***CDPHP reserves the right to review and audit charts as defined in the Participating Physician Agreement, Section 12.3.***

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