



CDPHP Prior Authorization/ Medical Exception Request Form

Fax or mail this form back to:

CDPHP Pharmacy Department, 6 Wellness Way., Latham, New York 12110-2145
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. Had 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):

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

CDPHP Prior Authorization/ Medical Exception Request Form (continued)

For weight loss medications:

1. Weight and date taken (must be within last 30 days) _____
2. Height _____ BMI (if known) _____
3. (BMI 27-29.9 only) Comorbid conditions _____
4. Current provider led diet/exercise program _____
5. Current length of provider led diet/exercise program _____

For migraine medications:

1. Migraine days per month (how long at that level): _____
2. Treating (acute) migraines: Triptan class medication trialed: _____

3. Preventing (chronic) migraines: Oral preventives trialed (i.e., beta blockers, topiramate, etc.)

For brand name antipsychotics (Vraylar, Rexulti, Caplyta, Lybalvi):

1. Previous trials of antipsychotics (drug, dose, and length of trial) (i.e., ariprazole, lurasidone, quetiapine, etc.)

2. Previous trials of antidepressants (for bipolar depression or major depressive disorder only) (i.e., SSRI, SNRI, Bupropion, etc.)

3. Previous trials of mood stabilizers (for bipolar I (manic/mixed only) (i.e., valproic acid, lamotrigine, lithium, etc.) _____

Prolia (for Osteoporosis only):

4. T-score (date and location of lowest score) or FRAX score and date done _____
5. Oral bisphosphonate (drug, dose, length of trial) _____
6. IV bisphosphonate (drug, dose, length of trial) _____

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.