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

continued ⇢

CDPHP Prior Authorization/ Medical Exception Request Form (continued)

For Weight Loss Medications: *Please provide all requested information.*
New Starts: *Complete Sections A* ***or*** *B* ***and*** *Section D for all requests.*
Continuations: *Complete Section C* ***and*** *D for all requests.*

Section A: Class 3 obesity (BMI 40 kg/m^2 or greater)

Weight and date taken (must be within last 30 days): _____

Height: _____ BMI (if known): _____

Section B: Class 2 obesity (BMI 35 to 39.9 kg/m^2)

Weight and date taken (must be within last 30 days): _____

Height: _____ BMI (if known): _____

(BMI 35-39.9 only) Comorbid conditions: _____

Section C: Continuation of therapy

Starting Weight: _____ Current Weight: _____

Section D: Comprehensive Weight Management Program (to be completed for all requests)

1. Is the member currently enrolled in a comprehensive weight management program?

   ☐ Yes (include program name) _____ ☐ No

2. Has the member been enrolled for the past 3 consecutive months? ☐ Yes ☐ No
3. Does the program include diet modification, meal-planning and/or a nutrition education component? ☐ Yes ☐ No
4. Does the program include an exercise component (at a minimum documentation of oversight/education to increase physical activity)? ☐ Yes ☐ No
5. Does the program address behavior modifications? ☐ Yes ☐ No
6. Is the member engaged in individual coaching or group sessions on a regular scheduled and ongoing basis? (This may be provider based counseling or inclusive of an approved program) ☐ Yes ☐ No

   - For initial approvals – Proof of current and prior participation in a comprehensive weight management program (such as a receipt or certificate and dietary/exercise logs) will be required
   - For continuations of drug approval beyond the initial coverage period will require provider acknowledgement (via prior authorization form or provider progress note) of continued comprehensive weight management program enrollment.

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.

**Response to this request will be done by telephone and in writing, not by fax.*