Pharmacy/Medical Drug Prior Authorization Form

Important: Use this form when requesting coverage for all drugs covered under either the pharmacy or medical benefit.

Providers are **strongly encouraged** to submit this form and all chart documentation via the Health Alliance Pharmacy Provider Portal. This will result in more reliable communication and expedited notification of determinations. Alternatively, if you are unable to access the portal, fax this form and all chart documentation to 217-902-9798. If you have questions, please call 1-800-851-3379, option 4.

☐ **Urgent** means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient's life/health, or the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

Section A – Member Information			
Today's Date:	First Name:		Last Name:
Member ID #:	Date of Birth:	Primary Insurance:	
Is this a ☐ **new request** or ☐ **a continuation of therapy** or ☐ **a retrospective request for payment**? Start date _____			
Were manufacturer samples provided? ☐ **Yes** ☐ **No** If yes, quantity/days of supply _____			
Are the drugs being requested as part of a clinical trial? ☐ **Yes** ☐ **No** If yes, list the clinical trial ID _____			
Is this patient currently hospitalized? ☐ **Yes** ☐ **No** If yes, include the anticipated discharge date _____			

Section B – Requesting Provider Information			
First Name:	Last Name:		
Address:	City:	State:	Zip code:
Phone:	Fax:	NPI:	
Specialty:	Email:	Contact Name:	
Participating provider? ☐ **Yes** ☐ **No** If no, do you have an approval to consult and treat? ☐ **Yes** ☐ **No** Auth #_____			

Section C – Rendering Provider Information for Medical Service Drugs (Buy-and-Bill)			
Is the rendering provider information the same as Section B? ☐ **Yes** ☐ **No** If no, you must complete Section C			
Facility/Provider Name:			
Address:	City:	State:	Zip code:
Phone:	Fax:	NPI:	
Participating facility/provider? ☐ **Yes** ☐ **No** If no, do you have an approval to consult and treat? ☐ **Yes** ☐ **No** Auth #_____			

Section D – Drug Formulary Exception Requests ***Please include a supporting statement and chart documentation***

Is this a request for any of the following exceptions to any formulary design? ☐ **Yes*** ☐ **No**

- ☐ Non-formulary Exception – Coverage of a drug not currently listed on the formulary.
- ☐ Quantity Exception – Coverage of a quantity of drug greater than the formulary limit.
- ☐ Tiering Exception – Reduce the tier of a formulary drug (Specialty drugs are exempt).
- ☐ Step-Therapy Exception – Request to bypass step therapy requirements.
- ☐ Prior Authorization Exception – The drug-specific prior authorization criteria should not apply to your patient.

Section E – Clinical Information of Drug(s) Requested ***Please include chart documentation***

Drug Name & Strength	HCPCS	Qty/Days	Dose Per Administration/Directions for Use/Frequency of Administration
ICD-10 code(s)			Procedure code(s)
Additional information related to the request			

Section F – List All Previous Treatments ***Please include chart documentation***

Drug Name/Therapy	Dates of Use	Reason for Failure

☐ I certify that the information provided is true and accurate to the best of my knowledge.

***The prescriber must submit a written supporting statement which explains why an exception is medically necessary.**

Prescriber's Signature_____ Date_____

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