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: _____

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 celecoxib request:

1. Short term use (30 days or less) pre/post a surgical procedure? . . . . . ◯ Yes ◯ No
2. Patient also utilizing oral steroids, anticoagulant or antiplatlet? . . . . . ◯ Yes ◯ No
3. Patient history of GERD, gastric/duodenal ulcer/bleed? . . . . . ◯ Yes ◯ No

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): _____

_____

_____

Practitioner Information

Practitioner Signature: _____

Practitioner Name: _____ Practitioner Phone #: _____

EIN: _____ NPI #: _____

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

_____ Nurse Contact: _____ Ext. _____

_____ Date of Request: _____

Please note: 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.