

## Non-Formulary Medications Prior Authorization

If this is an urgent request, please call Together with CCHP Pharmacy Services at 1-844-201-4677  
 Otherwise please return completed form to Together with CCHP Pharmacy Services by fax at 1-844-201-4675

### Past Relevant Medical Treatment

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

OFFICE CONTACT

PROVIDER FIRST NAME

PROVIDER LAST NAME

PROVIDER SPECIALITY

PROVIDER PHONE

PROVIDER FAX

PROVIDER NPI#

PATIENT NAME

PATIENT ID NO

PATIENT DOB

DRUG REQUESTED

STRENGTH

FREQUENCY

QTY DISPENSED (# of units)

Brand      Generic

**Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.**

New medication

Ongoing medication

If ongoing, please provide date started:

If medication is ongoing, did the member show improvement while on therapy?      Yes      No

Diagnosis:

Please indicate place of administration:      Physician's Office      Hospital/Facility      Patient Home  
 Other:

Please provide hospital/facility information:

NAME

PHONE

ADDRESS

Will the drug be: (select one):

Billed medically using a JCODE

Billed at a pharmacy

JCODE:

### History of medications used to treat above conditions

Specific clinical information is essential to determine whether this medication can be approved.

Have other medications been used in the past to treat this condition?      Yes      No

If yes, please provide the following information for ALL past medications tried:

Medication Name	Start Date	End Date	Strength	Frequency	Reason for failure /discontinuation
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Please provide any additional information which should be considered in the space below: