CONTRA COSTA HEALTH

IMPORTANT ANNOUNCEMENT
Please read carefully and
keep this letter for your records

Please start using the attached form now.

Please note that effective January 1, 2015, the California Department of Managed Healthcare (DMHC) under Title 28, California Code of Regulations, Section 1300.67.241, requires prescribers to use pharmacy prior authorization Form No. 61-211 for non-Medicare health plans. This form is attached below.

****Prior authorization requests submitted on other forms will not be accepted****

Fillable New Prior Authorization Forms

Prior Authorization Form No. 61-211 are located at these websites in convenient PDF format:

- https://www.cchealth.org/home/showpublisheddocument/921/638240916402370000
- Please fax the completed form to PerformRx at 1-866-205-8014 (standard) or 1-866-428-7369 (urgent) or Contra Costa Health Plan at 1-925-313-6412 (urgent).
- You may also call 1-925-957-7260, option 2 to have this form faxed to you. Business hours are 8am–5pm Pacific, M-F.

Online Prior Authorization Submission URLs

You may submit a prior authorization request online through PerformRx's web submission form:

- https://www.cchealth.org/health-insurance/information-for-providers/preferred-drug-list then click on the "PA Form Online" link.

Telephone Prior Authorization Submission

You may phone in prior authorization requests at 1-877-234-4269, option 2. The hours of business are 8am–5pm Pacific, M-F.

Please fax the following completed form to the number below:

Contra Costa Health Plan (BIN 019595, PCN PRX12397)
Pharmacy Prior Authorization Fax:
1-866-205-8014 (standard)
1-866-428-7369 (urgent)
1-925-313-6412 (urgent)

Need assistance?

Please speak to a CCHP Pharmacy Authorization Representative at 1-925-957-7260, option 2, 8am–5pm Pacific, M-F.

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#: (_____)** _____
Plan/Medical Group Fax#: (_____) _____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance			
First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm):_____Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information	
Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Patient's Home ☐ Long Term Care
☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**:_____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____