HIGHMARK HEALTH OPTIONS

Updated: 06/2024

Request for Prior Authorization for Medical Drugs
Website Form – www.wv.highmarkhealthoptions.com

MEDICAL DRUG PRIOR AUTHORIZATION FORM
Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.** If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:

Is the member currently receiving requested medication? ☐ Yes ☐ No   Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient?   ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital   ☐ Provider's office   ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement with treatment?   ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE
Please submit documentation including recent chart notes, diagnostic evaluations, test results, etc.

Prescribing Provider Signature	Date