

Medication Prior Approval Form

Instructions: Please fill out completely and fax to 517.364.8413. Applicable chart notes must accompany request. Prior authorization criteria and the drug formulary are available at www.phpmichigan.com/providers. Our office and fax machine are open M-F 8 am – 5 pm, except holidays.

Patient Information		Prescriber Information
Today's date:	Provider name:	
Member name:	Provider NPI #:	
Member's PHP ID#:	Office phone:	
DOB:	Office fax:	
Patient's weight:	Office contact:	
Gender:	Office address:	

Medication Information		
Medication:	Dose:	Frequency:
Diagnosis & ICD Code:	If this is a continuation of therapy, how long has patient been on the medication?	
If medication is an infusion medication, please also complete the following:		
HCPCS code:	This medication will be given: <input type="checkbox"/> In office <input type="checkbox"/> Hospital outpatient facility	Hospital/Facility name: Facility NPI #:

Previous therapies attempted:	Dose/frequency	Start and stop dates:	Reason for discontinuation
Additional comments here:			

OUTCOME (PHP use only)
<input type="checkbox"/> Approved – Good through:
<input type="checkbox"/> Not approved – Reason:
Pharmacist/Designee Signature and date: