PRIOR AUTHORIZATION REQUEST (PAR)-DH MANAGED CARE

Please allow 72 hours for request to be completed. Call 303-602-2070 or 877-357-0963 with questions. **After all portions are complete, fax to: 303-602-2081 or submit via email to**: ManagedCarePAR@dhha.org. All areas MUST BE COMPLETED in order to process this request form. Please print legibly.

PATIENT INFORMATION (May be completed by pharmacy staff if applicable)			Date Initiated: | |
Last:	First:		Sex: M F
Insurance#:	DH Medical Record #:	Date of Birth: | |	Phone #: ( ) -
DHHA CSA/DERP DPPA CHP+ DH Medicaid DH Medicare Elevate			
Drug:	Generic OK? Yes No	Strength:	Qty:
Rx Directions:			
Prescriber:		**DH Staff Provider?** Yes No	Clinic Fax #:
To be filled at: Webb Pharmacy Central Fill (mail order) Eastside La Casa Pharmacy Westwood Montbello Park Hill Lowry Westside Pharmacy Public Health Pharmacy DH Discharge Pharmacy Pena Other			

CLINIC PORTION (May be completed by provider or other designated individual)		
New Request **Renewal Request** **Urgent (Life Sustaining Only)****		
Attending **Fellow** **Resident**	Pager:	Clinic Name:
Contact Person:	Phone #: ( ) -	Clinic Fax #:
Completed By (if different):	Email Address (if non-DH):	
Patient diagnosis:		
How long will patient be on this med?		
Will drug need to be titrated? Yes No	If yes, what doses?	
Medical Rationale/Necessity - May provide clinical documentation for medical necessity (i.e. encounters, lab, radiology, etc.):		
Is the patient currently receiving this drug? Yes No	If yes, greater than 3 months? Yes No	
Please list all other medications the patient has tried for this diagnosis and duration of use.		

**For after-hours urgent requests, please call the MedImpact help desk at 800-788-2949