DENVER HEALTH MEDICAL PLAN INC.™

PRIOR AUTHORIZATION REQUEST FORM – PHARMACY

Please allow 72 hours for request to be completed. Call 303-602-2070 or 877-357-0963 with questions. For urgent after-hours requests, please call the MedImpact help desk at 800-788-2949. All fields must be completed in order to process this request form. Please print legibly.
Once completed, fax form to 303-602-2081 or submit via email to ManagedCarePAR@dhha.org.

PATIENT INFORMATION (may be completed by pharmacy staff if applicable)			Date Initiated: | |
Last:	First:		Sex: ◯ M ◯ F
Insurance#:	Medical Record #:	Date of Birth: | |	Phone #: ( ) -
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 ◯ Outpatient Medical Center Pharmacy (OMC) ◯ 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 #:

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 30 days? ◯ Yes ◯ No

Please list all other medications the patient has tried for this diagnosis and duration of use.