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?	

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PRIOR AUTHORIZATION REQUEST FORM – PHARMACY CONTINUED

CLINIC PORTION (may be completed by provider or other designated individual)	
Please provide clinical documentation for medical rationale/necessity (i.e. encounters, lab, radiology, etc.) and also list all other medications the patient has tried for this diagnosis and duration of use.	
Is the patient currently receiving this drug? ◯ Yes ◯ No	If yes, greater than 30 days? ◯ Yes ◯ No