



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

SWHP Non-Formulary Drug Request

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
	Supervising Physician:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please indicate diagnosis and ICD code.
Q2. What are the quantity and days supply requested?
Q3. Please indicate reason for request.
Q4. Is the patient a new start to therapy? If no, please provide start date. <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Please indicate other formulary drugs for this condition that the patient has tried/failed. Formulary can be found at: https://swhp.org/en-us/prov/resources/pharmacy-services/drug-list
Q6. Please indicate formulary drugs that the patient cannot take for this condition and provide rationale for not using.



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Patient Name:	Prescriber Name: Supervising Physician:
Q7. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement? <input type="checkbox"/> Pharmacy <input type="checkbox"/> Individual prescriber <input type="checkbox"/> Provider or specialty group <input type="checkbox"/> Facility <input type="checkbox"/> Other (please specify)	
Q8. Provide name and NPI of the billing entity	
Q9. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)? <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy	
Q10. Additional Comments:	

Prescriber Signature

Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.



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