Summit COMMUNITY CARE

Prior Authorization Form for Medical Injectables

This prior authorization (PA) form and PA criteria may be found at https://www.summitcommunitycare.com/provider. If the following information is not complete, correct and/or legible, the PA process can be delayed. Please use one form per member. Please allow Summit Community Care at least 24 hours to review this request. For telephone requests or questions, please call 1-844-462-0022. Fax this completed form to 1-844-429-7762.

Member information (required):

Last name	First name	MI	Summit Community Care ID	Date of birth	Sex (circle one) ☐ M ☐ F
Member's place of residence: ☐ Home ☐ Nursing facility Administration site: ☐ Home ☐ Office ☐ Outpatient facility			Height	Weight	Date of service

Prescriber information/demographics:

Last name	First name	MI	NPI number	Tax ID number
Address where service was rendered			City	
State	ZIP code	Telephone number ( )		Fax number ( )
Office contact name				Contact direct phone number ( )
Is the above address also the billing address? ☐ Yes ☐ No (If no, please complete below.)				

Billing facility information:

Name			NPI/Tax ID number (required)	DEA/license number
Address where service was rendered			City	
State	ZIP code	Telephone number ( )		Fax number ( )
Office contact name				

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All services referenced in this material are funded and provided under an agreement with the Arkansas Department of Human Services.
ARPEC-0144-18 November 2018

Medication information:

Drug name and strength requested	SIG (dose, frequency and duration)	HCPCS billing code

Diagnosis and/or indication	ICD code (required)

Has the member tried other medications to treat this condition?	Drug name(s) and strength	
☐ **Yes.** Provide this information in the area to the right. You may be asked to provide supporting documentation, such as: • Copies of medical records. • Office notes. • A completed *FDA Medwatch* form.	Date range of use	SIG (dose and frequency)
	Did the member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other	
☐ **No.** Explain why not: _____ _____ _____	Briefly describe details of adverse reaction, inadequate response or other in the space provided below. _____ _____ _____	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling
List all current medications including dose and frequency
Other pertinent information

Diagnostic studies and/or laboratory tests performed (List all tests done within the past 30 days that are related to diagnosis of medication requested.)

Labs			**Diagnostic tests**		
Test	Date	Result	Procedure	Date	Result

Signature:

Prescriber's signature (required) Date

(By signature, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission or concealment of material may be subject to civil or criminal liability.)