Summit COMMUNITY CARE

Pharmacy Prior Authorization Form

Instructions:

1. Complete this form in its entirety. Any incomplete sections will result in delayed processing.
2. We review requests for prior authorization based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Summit Community Care (including current member eligibility, other insurance, and program restrictions). We will notify the provider and the member's pharmacy of our decision.
3. To help us expedite your Medicaid authorization requests, please fax all the information required on this form to **844-429-7761**.
   Allow us at least 24 hours to review this request. If you have questions regarding a Medicaid prior authorization request, call us at **844-462-0022**. The pharmacy is authorized to dispense up to a 72-hour supply while awaiting the outcome of this request. Please contact the member's pharmacy.
4. Access our website at **https://www.summitcommunitycare.com/provider** to view the *Preferred Drug List*.
5. An ICD/diagnosis code is required for all requests. A HCPCS billing code is required for all medical injectable/oncology requests. If the billing facility is different from the requesting physician, you will need to complete the billing facility information.

Member information

First name	Last name	MI	Member ID #:	DOB:	Sex (Circle one.): ☐ F ☐ M
Member's place of residence: ☐ Home ☐ Nursing facility Administration site: ☐ Home ☐ Office ☐ Outpatient facility			Height:	Weight:	

Medication information

Drug name and strength requested:	SIG (dose, frequency, and duration):	HCPCS billing code:
Diagnosis and/or indication:		ICD code:

Has the member tried other medications to treat this condition? ☐ 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. • Complete *FDA MedWatch* form. ☐ No, explain why not:	Drug(s) name and strength:	
	Date range of use:	SIG: (dose and frequency)
	Did the member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other 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

Prescriber information

First name	Last name	MI	NPI # (required):	DEA/license #:
Address where service was rendered:			City:	State:
ZIP code:	Telephone #:		Fax number #:	
Office contact name:			Contact direct phone #:	

Billing facility information

Name:		NPI/tax ID # (required):	DEA/license #:
Address:		City:	State:
ZIP code:	Telephone #:	Fax #:	Office contact name:

Pharmacy information

Name:	Pharmacy NPI #:	Telephone #:	Fax #:

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material may be subject to civil or criminal liability.

Prescriber's signature (or authorized representative) Date