



# News Flash



## Important Pharmacy Information

**To:** Sharp Health Plan Providers  
**Attn:** Providers & Provider Office Staff  
**From:** Sharp Health Plan  
**Date:** October 24, 2017  
**Subject:** **New Prescription Drug Prior Authorization/Step Therapy Exception Request Form Effective January 1, 2018**

Attention Provider Partner:

On January 1, 2018, the California Department of Managed Health Care (DMHC) under Title 28, California Code of Regulations Section 1300.67.24.1, will require prescribers to begin using the new Prescription Drug Prior Authorization/Step Therapy Request Form No. 61-211 for all non-Medicare health plans. A copy of Form No. 61-211 is included with this fax.

### Beginning January 1, here's what you need to know:

- You **must** use the new form, or your request will not be accepted.
- You **must** use the new form to request prior authorization for prescription drugs obtained through the outpatient pharmacy benefit, and through the medical benefit (injectables, home infusion, etc.).
- **The process will not change.** Please continue faxing your pharmacy prior authorization requests for outpatient pharmacy medications (non-injectable) to Sharp Health Plan at 1-858-357-2534.

For your convenience, we will accept *either* the existing or new form through December 31, 2017. You can access the existing form on our website at [sharphealthplan.com/drugpriorauthform](http://sharphealthplan.com/drugpriorauthform). Beginning January 1, this form will be replaced with the new one.

If you have questions, contact Provider Relations at (858) 499-8330 or [provider.relations@sharp.com](mailto:provider.relations@sharp.com). We are available to assist you Monday - Friday, 8 a.m. to 5 p.m.

Warm regards,

Kate Tepedino, PharmD  
Manager, Pharmacy Benefits

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## PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: \_\_\_\_\_ Plan/Medical Group Phone#: (\_\_\_\_\_) \_\_\_\_\_  
 Plan/Medical Group Fax#: (\_\_\_\_\_) \_\_\_\_\_ Non-Urgent  Exigent Circumstances

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

### Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:		City:	State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

### Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

### Prescriber Information

First Name:	Last Name:	Specialty:
Address:		City: State: Zip Code:
Requestor (if different than prescriber):		Office Contact Person:
NPI Number (individual):		Phone Number:
DEA Number (if required):		Fax Number (in HIPAA compliant area):
Email Address:		

### Medication / Medical and Dispensing Information

Medication Name:			
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____			
How did the patient receive the medication?			
<input type="checkbox"/> Paid under Insurance    Name: _____		Prior Auth Number (if known): _____	
<input type="checkbox"/> Other (explain): _____			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
Administration:			
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____			
Administration Location:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care	

## PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:
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**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

<b>1. Has the patient tried any other medications for this condition?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>Medication/Therapy</b> (Specify Drug Name and Dosage)	<b>Duration of Therapy</b> (Specify Dates)	<b>Response/Reason for Failure/Allergy</b>
<b>2. List Diagnoses:</b>		<b>ICD-10:</b>
<b>3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.</b>		
<p>Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.</p> <p><input type="checkbox"/> Attachments</p>		

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Plan/Insurer Use Only:**    Date/Time Request Received by Plan/Insurer: \_\_\_\_\_    Date/Time of Decision \_\_\_\_\_

Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

Approved     Denied    Comments/Information Requested: \_\_\_\_\_