Drug Health Services Review Form
(Formerly Drug Prior Authorization Form)

Anthem
And Its Affiliated HMOs

This form is used for drugs requiring health services review and requests exceeding plan limitations (i.e. travelling out of the country). **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE HEALTH PLAN AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC PLAN LIMITATIONS.** In case of medical emergencies, physicians may contact 800-533-1120. Requests may be mailed to:
Pharmacy Program, P.O. Box 746000, Cincinnati, OH 45274

PATIENT INFORMATION

Patient's Name:	Identification Number (as shown on ID card) (Letters if any) (___ ___ ___) ___ ___ ___ ___ ___ ___ ___ ___ ___
Patient's Date of Birth:	Patient's Address/City/State/Zip:
Patient's Diagnosis:	
Policyholder's Name:	

DRUG INFORMATION
Do Not Use This Form for Synagis Requests. Synagis Requires a Separate Form Available at www.anthem.com

Drug Name & Strength (see questions below	Quantity Per Month: (see questions below)

HEALTH SERVICES REVIEW REQUEST(S)
Please respond to the appropriate questions. Incomplete information will delay processing of your request.

MOBIC/ CELEBREX:

- Please list names, dosages and dates of Rx NSAIDs or Salicylates previously tried.

_____

_____

LUPRON: (Mark below as appropriate.)

☐ Endometriosis
- Date & results of laparoscopy:
- Is patient scheduled for endometrial ablation? ☐ **Yes** ☐ **No**

☐ Fibroids
- Tentative Date of myomectomy/vaginal hysterectomy:
- Anemia prior to surgery/HCG count:

☐ Current symptomology (including uterus size in weeks):

INFERTILITY MEDICATIONS: (Clomiphene, Crinone, Fertinex, Gona-F, Humegon, Metrodin, Pergonal, Profasi, etc.)

- Are there any assisted therapies being planned or utilized? (i.e. IUI, GIFT, ZIFT, AI, IVF, etc) ☐ **Yes** ☐ **No**
- For HMO contracts only, proved the Authorization Approval #: Approval Dates:

PROVIGIL: Diagnoses of Sleep Apnea, Idiopathic Hypersomnia or Narcolepsy require a sleep study confirming diagnosis

AXERT / MAXALT / IMITREX / ZOMIG / AMERGE / FROVA / RELPAX (Provide info below for quantities > 12 per month)

- Provide Current treatment plan to reduce the frequency & duration of migraine headaches:
- List Current preventatives (Do not list past treatment failures. Patient must be utilizing an effective migraine preventative agent to have the request considered).
- List the patient's migraine frequency and the amount of medication needed for a 30-day supply.

WEIGHT LOSS: Provide height, weight and other medical conditions

GROWTH HORMONE: Provide current height & velocity, complete growth curve, last clinical note, and two provocative tests

MISCELLANEOUS:

- Drug: Previous Therapies:

REQUEST FOR QUANTITY INCREASE

Reason for request:
☐ Traveling out of the country - Length of time traveling out of the country:
☐ Quantity limit exceeded - Explain

List all medications needed and quantities taken per day:

PHYSICIAN INFORMATION

Physician's Name (print):	Date:
Physician's Signature:	Phone #:
Physician's Address/City/State/Zip:	FAX #:

Prior Authorization Center Phone: 800-338-6180 or FAX TO 800-601-4829
HEALTH SERVICES REVIEW CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE