PRIOR AUTHORIZATION FORM

DuPage Mental Health Services, LTD.

1751 S. Naperville Rd. Suite 207
Wheaton, IL 60189

THIS FORM INCORPORATES GUIDELINES FROM MANAGED CARE REFORM AND PATIENTS RIGHTS ACT

Today's Date: _____

Patient Information

Member Gender: Male or Female

Member First Name: _____

Member Last Name: _____

Member ID# _____ Group # _____

Member DOB: _____

Member Phone #: _____

Member address: _____

State: _____ Zip Code: _____

Prescriber Information

Prescriber Name: _____

Prescriber Specialty: _____

Prescriber DEA/NPI: _____

Prescriber Phone # _____

Prescriber Fax # _____

Prescriber address: _____

State: _____ Zip Code: _____

Urgency of Review

Is this request urgent? ( ) Yes ( ) No

Urgent is defined as when the physician believes that waiting for a standard review (typically 3-5 business days) could seriously harm the patient's life, health, or ability to regain maximum function.

Information about Medication being requested *For items with an asterisk please refer to the attached Act.

Name: _____ Strength: _____ Dosage form: _____

Quantity (per month): _____ Directions: _____

Currently Taking: Y or N Expected length of therapy: _____

* Is the medication covered on the health benefit plan's formulary? [ ] Yes [ ] No

* Is the health benefit plan discontinuing the coverage on the formulary for reasons other than safety or removal from the market? [ ] Yes [ ] No

Is the medication for continuation of therapy? Y or N If yes, when was medication first started? _____

Brand Name: _____ Generic: _____ (check which one is being requested)

If Brand Name, did the patient try generic and not respond? _____ When? _____

Has the patient previously taken the requested medication at any time in the past and discontinued its use? [ ] Yes [ ] No

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Diagnosis: _____ ICD Code plus description: _____

_____

Diagnosis should pertain to medication being requested.

Reasons for Requesting: (Check any that apply) ***For items with an asterisk please refer to the attached Act**

ITEMS SEPCIFIC TO THE MEDICATION BEING DISCUSSED:

Indicated (FDA approved) for the diagnosis ___ Yes ___ No
If checked yes, please look at attached sheet for the diagnostic criteria patient is meeting.

____ Patient is allergic to alternative medication

____ *The Required Prescription Drug Alternative/s are contraindicated

____ Failure on other FDA approved medications for the indicated diagnosis

____ *Evidence of failure on Required Prescription Drug Alternative/s for the indicated diagnosis

____ *Required Prescription Drug Alternative/s are likely to be ineffective based on medical evidence and characteristics of patient

____ Intolerance to other FDA approved medications for the indicated diagnosis

____ *Evidence of intolerance to Required Prescription Drug Alternative/s for the indicated diagnosis

____ *The Required Prescription Drug Alternative/s have caused an adverse reaction or harm to the patient

____ *The Required Prescription Drug Alternative/s are likely to cause an adverse reaction or harm to the patient

____ *The patient is stable on a prescription drug used for the indicated diagnosis

____ Clinical Drug Trial Request

_____

ITEMS SPECIFIC FOR MEDICATION DOSING:

____ *The number of doses available has been ineffective in the treatment of the medical condition

____ * The number of doses available is likely to be ineffective based on medical evidence and characteristics of the patient

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History of Alternative Treatment for Diagnosis

*Required Prescription Drug Alternative = RPDA

List of all medications the patient has previously **tried and failed** for treatment of this diagnosis (Brand name or Generic?)
Medical records including chart notes are being provided for documenting previous therapy failures.

Name of Medication	Brand or Generic	Date	FDA approved	Not approved	RPDA*	Reason for Discontinuation
_____	B or G	_____	_____	_____	_____	_____
_____	B or G	_____	_____	_____	_____	_____
_____	B or G	_____	_____	_____	_____	_____
_____	B or G	_____	_____	_____	_____	_____

Please list other medications the patient will use in combination with the requested medication for treatment of this diagnosis:

Name of Medication	Brand or Generic	Date
_____	B or G	_____
_____	B or G	_____
_____	B or G	_____
_____	B or G	_____

Quantity Limit Requests ONLY:

The quantity requested PER DAY? _____
The reason for exceeding the plan limitations:
[ ] Titration or loading-dose purposes
[ ] Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
[ ] Requested strength/dose is not commercially available
[ ] There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency.
[ ] Other, **specify:** _____

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General Questions

Is the request for a patient with one or more chronic conditions who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? Specify anticipated significant adverse event: _____

_____

Does the patient have a chronic condition confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____

_____

Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____

Does the patient require a specific dosage form? (e.g., suspension, solution, injection?) If so, provide dosage form: _____

Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, provide risk factors: _____

_____

Has this drug been identified by the Centers of Medicare and Medicaid Services as a high-risk medication in the 65 and older population?
[ ] Yes [ ] No
If so, does the provider wish to proceed with the original prescribed medication? [ ] Yes [ ] No

Please document the intended length of therapy: _____

For patients who have or will exceed the plan limit of a 90 day supply in a 365 day period:
Explain medical/ scientific evidence you have that supports safe use of this high-risk medication for more than 90 days in patients age 65 and older: _____

_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

Provider Signature: _____ **Date:** _____

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ATTACHMENT TO PRIOR AUTHORIZATION FORM

PHRASES/SENTENCES HAVE BEEN BOLDED WITH ASTERISKS REFERRING TO CONTENT IN FORM

INSURANCE
(215 ILCS 134/) Managed Care Reform and Patient Rights Act.

(215 ILCS 134/45.1)

Sec. 45.1. Medical exceptions procedures required.

(a) Notwithstanding any other provision of law, on or after the effective date of this amendatory Act of the 99th General Assembly, every insurer licensed in this State to sell a policy of group or individual accident and health insurance or a health benefits plan shall establish and maintain a medical exceptions process that allows covered persons or their authorized representatives to request any clinically appropriate prescription drug when (1) *the drug is not covered based on the health benefit plan's formulary; (2) *the health benefit plan is discontinuing coverage of the drug on the plan's formulary for reasons other than safety or other than because the prescription drug has been withdrawn from the market by the drug's manufacturer; (3) the prescription drug alternatives required to be used in accordance with a step therapy requirement (A) *has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance or (B) *has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to the enrollee; or (4) the number of doses available under a dose restriction for the prescription drug (A) *has been ineffective in the treatment of the enrollee's disease or medical condition or (B) based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.

(b) The health carrier's established medical exceptions procedures must require, at a minimum, the following:

(1) Any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals.

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(2) The health carrier must, within 72 hours after receipt of a request made under subsection (a) of this Section, either approve or deny the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(3) In the case of an expedited coverage determination, the health carrier must either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(c) A step therapy requirement exception request shall be approved if:

(1) *the required prescription drug is contraindicated;

(2) *the patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or

(3) *the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

(d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy or contract up to the quantity covered.

(e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan.

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(f) Notwithstanding any other provision of this Section, nothing in this Section shall be interpreted or implemented in a manner not consistent with the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those Acts.

(g) Nothing in this Section shall require or authorize the State agency responsible for the administration of the medical assistance program established under the Illinois Public Aid Code to approve, supply, or cover prescription drugs pursuant to the procedure established in this Section. (Source: P.A. 98-1035, eff. 8-25-14; 99-761, eff. 1-1-18.)