# FLORIDA HEALTH CARE PLANS
# PRIOR AUTHORIZATION MEDICATION FORM
### Phone: 386-238-3230 / 800-352-9824

**Florida Health Care Plans**
An Independent Licensee of the Blue Cross and Blue Shield Association

### Please fax completed form with CLINICAL NOTES and MED LIST to
### FHCP Central Referrals at 386-238-3253 or 855-442-8398
*Note: If clinical documentation is not received with this request, request may result in a denial.*

You may view the formulary online at **www.fhcp.com** by clicking on the "For Providers" Link, then click "Resources and Support", then select "View Member Formularies", then "Medication Formulary" to determine whether a medication requires prior authorization.

**DATE:**          NOTE: **ALL BOXES MUST BE COMPLETED FOR REQUEST TO BE REVEIWED**

| Provider's Name including credentials: | Provider Signature: |
|---|---|
| Specialty: | **ADDRESS** and name of office/facility: |
| Contact Person:          Phone/Ext: | Provider Phone:          Provider Fax: |

Routine ☐

**Urgent** ☐ STOP  **Phone: 386-238-3230 *or* 800-352-9824**
**If your request is urgent, you must call the Central Referral Department prior to submitting your request.** **Urgent is serious jeopardy to life, health, maximum function**

| Patient Name: | | FHCP #: | | DOB: | |
|---|---|---|---|---|---|
| Patient Home Phone: | | | Patient Alternate Phone: | | |

| Name of Medication | Strength | Dosing Instructions/Route of Administration | Duration of Therapy |
|---|---|---|---|
| | | | |

☐  Brand name ONLY  **REASON FOR BRAND ONLY:**

New Start/Initiation of Therapy                    Continuation of Therapy

| Diagnosis: | ICD10 Code: |
|---|---|

If infusion or injection, will requesting provider be administering medication?
**WILL THE MEDICATION BE:** ☐ **Provided by Pharmacy**     ☐ **Provided by Office**

Alternatives tried:

Reason for the Medication: