TOTAL HEALTH CARE

Medical Drug Prior Authorization Form

Fax form to: **313.871.6229**

Member

Last Name: ______________________ First Name: ______________________

THC ID # ______________________ DOB: ______________________

Requesting Provider: ______________________ Prov. Phone: ____________ Prov. Fax: ____________

Provider Address: ______________________ Contact Name: ______________________

Provider NPI: ______________________ Servicing Facility NPI: ______________________

Product Information

Medication: ______________________ CPT/HCPC Code: ____________ Strength: ____________

Frequency: ________ time(s) per: ☐ day ☐ week ☐ month Total Units: ____________

Start Date: ____________ End Date: ____________

Medication: ______________________ CPT/HCPC Code: ____________ Strength: ____________

Frequency: ________ time(s) per: ☐ day ☐ week ☐ month Total Units: ____________

Start Date: ____________ End Date: ____________

Medication: ______________________ CPT/HCPC Code: ____________ Strength: ____________

Frequency: ________ time(s) per: ☐ day ☐ week ☐ month Total Units: ____________

Start Date: ____________ End Date: ____________

Medication: ______________________ CPT/HCPC Code: ____________ Strength: ____________

Frequency: ________ time(s) per: ☐ day ☐ week ☐ month Total Units: ____________

Start Date: ____________ End Date: ____________

Medication: ______________________ CPT/HCPC Code: ____________ Strength: ____________

Frequency: ________ time(s) per: ☐ day ☐ week ☐ month Total Units: ____________

Start Date: ____________ End Date: ____________

Medication: ______________________ CPT/HCPC Code: ____________ Strength: ____________

Frequency: ________ time(s) per: ☐ day ☐ week ☐ month Total Units: ____________

Start Date: ____________ End Date: ____________

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide published peer-reviewed literature articles supporting the drug's use for the identified indication.

THC form ID: ____________

Total Health Care Precertification Documentation

A. List the patient's medical condition the drug is being requested for: _____

B. Explain the medical reason for this request.

_____

_____

_____

C. List previous drugs the patient tried. (List the name, date prescribed, and any other important information.)

Drug name	Strength	Dosing schedule/frequency	Date prescribed	Date stopped

D. Provide any additional information for consideration (optional)**:**

_____

_____

THC form ID: _____

All fields must be complete and legible for review.