HEALTH FIRST
Health Plans

Health First

6450 US Highway 1, Rockledge, FL 32955

Additional copies of this form can be found on the HFHP Provider Portal Website located at:
https://myhfhp.health-first.org

Pharmacy Authorization / Exception Form

Customer Service
Phone: (321) 434-5665
Toll Free: (800) 716-7737
TDD Relay: (800) 955-8771

FAX COMPLETED FORM AND SUPPORTING DOCUMENTATION TO: **(321) 434- 4752**

ALL REQUESTED INFORMATION MUST BE PROVIDED FOR CONSIDERATION FOR COVERAGE.
PLEASE TYPE OR PRINT CLEARLY

Step 1: Patient & physician information

Patient Information	Requesting Physician Information	Performing Physician Information
First Name:	Physician Name:	☐ Check here if same as requesting Physician Name:
Last Name:	Contact Person:	
DOB: ___/___/___	Phone: (___) ___ Ext. ___	Phone: (___) ___
Health First ID #:	Fax: (___) ___	Fax: (___) ___

Step 2: Diagnosis and Medical Information

Drug Name:		Strength and Route of Administration:	Dosage/ Frequency:	Patient Weight:
Qty:	Place Of Service: ☐ Physicians Office ☐ Pharmacy ☐ Home Agency	Expected Length of Therapy:	HCPCS Code:	☐ New Prescription OR Date Therapy Initiated:
Drug Allergies (if applicable):		Diagnosis:		
		ICD-9 Code:		

Step 3: Rationale for Exception Request or Prior Authorization

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure)
→ **Specify below:** (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change

→ **Specify below:** Anticipated significant adverse clinical outcome

☐ Other: Explain below

REQUIRED EXPLANATION: ___

☐ Please check here if the patient is receiving this medication as part of a clinical trial

Request for Expedited Review

CRITERIA FOR EXPEDITED REVIEW: IF WAITING FOR A DECISION IN THE STANDARD TIMEFRAME COULD SERIOUSLY HARM THE MEMBER'S LIFE, HEALTH OR ABILITY TO REGAIN MAXIMUM FUNCTION, YOU CAN ASK FOR AN EXPEDITED (FAST) DECISION.

CHECK HERE IF YOU ARE REQUESTING A FAST DECISION AS DESCRIBED BY THE CRITERIA ABOVE: ☐

HFHP Only

☐ Approved: Authorization Number: ___ Authorization Expiration Date: ___/___/___

Additional Information Needed: ☐ Office notes ☐ Clinical information ☐ Diagnosis code ☐ Member ID # ☐ Member name ☐ Physician name ☐ Patient height and weight

☐ Other: ___

Completed by: ___ **Date:** ___/___/___ **Phone:** (321) ___ - ___
(Authorized Health First Health Plans Signature)

USE OF THIS FORM DOES NOT GUARANTEE ELIGIBILITY OF COVERAGE AND DOES NOT SUPERCEDE ANY MEMBER BENEFIT PLAN LIMITATIONS OR THE PROVIDER'S CONTRACTUAL LIMITATIONS.

AFFIRMATIVE STATEMENT: UM decision making is based only on appropriateness of care and service and existence of coverage. HFHP does not reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.